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Necessary Ingredients

For a long time now, appeals have been made through the newspapers, over the radio, in the nursing literature, and by various other means, for more and more nurses to help to meet the demands for nursing care. Hundreds and thousands of married or retired nurses have answered these calls and are today filling positions in our hospitals, with public health organizations or carrying on in private duty. Many of these nurses have home responsibilities, in addition, and are therefore working a good deal longer than the regular eight-hour day. Many are beginning to feel that the work is an effort but since the job has to be done, they remain on duty. Usually only one part of an individual is used up in doing any particular piece of work. Other parts get dammed up and a pause is necessary to enable the nurse to become a whole person again. This pause we call the leisure period, and a brief consideration of how it can be made most profitable may help us to meet the commotion and rush of the busy days that lie ahead with great equanimity.

"Doing" and "not doing" are both aspects of being. When at work, the nurse is *needed*. Relaxation comes when necessity is withdrawn from her activities. The moment that work stops, she becomes less important, temporarily, and enters a period of indifference to external pressure. There is an element of choice open to her and a chance of making values, as it were, from within.

Many people cannot just slip from work — they have to throw it off. The hours on duty have involved a certain tightening up. While loosening up again, one must do nothing or appear to be doing nothing. Washing, tidying, a change of dress, a bath, even lounging, are very useful ways of loosening up, of relaxing. It is important to remember that if we are with other people, we can relax best when they do not set up tensions or remind us of tensions set up earlier. Laughter is a prime relaxing agent.

Both body and mind should relax — the body in as pleasant and comfortable surroundings as possible, the mind in light reading, chatting with contemporaries, etc.

If relaxation leads on to recreation, the nurse will emerge re-created. Perhaps, because the off-duty hours are usually filled with endless trivialities which obscure our perspective, it is difficult to work out a purpose or plan which might justifiably be called adequate. George Herbert, who wrote at the turn of the sixteenth century, said "He hath no leisure who useth it not". Since leisure should be of a kind which automatically reduces all personal problems to a minimum, the solution probably lies in developing hobbies, preferably two; one for indoors and one for out, even though they may point in opposite directions.

A hobby is one's favorite subject or occupation that is not one's main business. It is healthy if it can be laughed at and/or shared. There are endless varieties of things which can be taken up as hobbies. Perhaps the commonest is some form of collecting. People often associate the starting of a collection of articles with the pre-adolescent years but no nurse is too old to begin. The chief difference will lie in the type of objects collected. Books, recorded music, pictures, stamps, china — she can go on listing until she finds the thing she is most interested in and her hobby starts there. For the nurse who is skilled with her hands, there is an infinite range of things she can make. Out-of-door hobbies include not only the various sports but again the collecting urge may be satisfied.

Over two thousand years ago, Dionysius the Elder, being asked whether he was at leisure, replied, "God forbid that it should ever befall me". We have learned a great deal since then. We know there is something wrong with the person who has no outside interests, who does not use her leisure. Let us relax and recreate so that we may do our work more efficiently.

—M. E. K.

February

Though February is so brief, she is intriguing, quite, when trees are innocent of leaf, and days are short but bright. Beneath our feet how crisp the snow, o'erhead, how blue the sky, with all the blustering winds that blow as clouds go scudding by. One day the gentler note of Spring comes floating on the air, reminding us of birds that sing, the flowers that bloom so fair. And on the wings of that glad thought our hearts are light and merry as on our calendar we jot adieu to February.

—Mary M. Forman

Preview

Inaugurating what we hope will grow into a regular feature of the *Journal*, the March issue will feature a composite picture of the present-day knowledge of Rheumatic Fever. Dr. James H. Graham will introduce the topic with a discussion of the causes of the disease, the symptoms, and both the therapeutic and suggested prophylactic treatment. Mildred M. Brogan outlines the nursing care in the acute stage. Evelyn Pibus rounds out the study with an analysis of the public health aspects and some sound advice to nurses going into the homes.

Legal Responsibilities and Privileges

TRENHOLM L. FISHER, M.D., F.A.C.P.

There can be no doubt that if you had found the proper member of the legal profession he could have given you a more precise definition of the legal responsibilities and privileges of the nursing profession than I can. Such knowledge as I have has been gathered rather by indirection than by deliberate intent in the course of some duties which make it necessary for me to decide, always with Counsel at my back, where physicians' responsibilities begin and end. There have been occasions when these have impinged on nursing responsibilities and anything I can say to you has become known to me in that manner.

Here I would like to thank Mr. E. F. Newcombe, K.C., General Counsel of the Canadian Medical Protective Association, for the help he gave me. He read over the first draft, culled many of the inaccuracies, and added much valuable information that otherwise you would not have had.

Not many of us give the law more than a passing glance when we are afraid we have transgressed in some particular and for that reason most of us, when we do meet it, have a slight rise in blood pressure and a fervent hope that we may never have any closer acquaintance. A few of us shun it because we agree that "the law is a ass". All of us who hold those opinions forget the other side of the question. We forget that the law represents a great part of the accumulated wisdom that men have acquired about how to live with each other, how to define their several positions and, even more important, how to protect themselves from predatory action of any kind by their fellows. The law, as well as forcing us to accept some responsibilities, protects us against unfair demands.

Then, too, nearly all of us fail to realize that while the law can be and is very specific about many things it is a body of opinion arrived at by and laid down for ordinary persons who are engaged in many diverse activities. Obviously it would be impossible to be specific about every particular activity and, therefore, the law tends to lay down general principles which may be regarded as more or less fixed, at least *pro tem*, and to apply these principles to the solution of particular problems. When once a solution has been arrived at, it often is used in subsequent similar cases. In other words, it becomes a precedent and while it is not "law" it has the force of law because, again *pro tem*, it is the best solution available for the particular problem.

This fact is of the greatest importance with respect to medical and nursing legal problems. It is literally true that there are no specific "laws" stating what a nurse may or may not do, or — if rarely she be lazy — how little she can do. Nursing responsibilities are poorly defined in law. Actually, reference to such legal literature as I have been able to obtain suggests there are no "laws" governing the responsibilities and the conduct of nurses, although their own Registration Act does define, to some extent, their privileges. Although if precedents hold there are few to follow because comparatively few nurses have been brought to court to have their conduct judged — I leave it to you to decide whether the profession as a whole has earned this untroubled state! Further, as with any profession, the profession of nursing has changing responsibilities which force changes in the application of the law. The many new duties, some accepted eagerly and some reluctantly, which have devolved upon nurses as a result of the present short-

age, are a case in point. Many of them will be relinquished gladly when the emergency is over, but a few will remain and new precedents will be found to govern the manner in which such duties must be fulfilled. So, with respect to the nursing profession not only are laws few and general in application, but due to changing circumstances the applications of the general principles are constantly changing. What is unusual for a nurse to accept as her duty today may be commonplace and accepted tomorrow.

Now let us see if we can decide from a nursing point of view what are the duties of nurses, and then perhaps we can apply some legal principles to these activities. First and foremost, of course, really the only reason for a nursing profession is the nursing care of patients. This care is made up of several things. The actual physical care of the patient, the provision of cleanliness and comfort and optimum conditions for cure are basic things and have been basic since there was a nursing profession. With the greater education and increased knowledge of that profession over the years, more and more actual medical treatment, under the guidance of doctors, has been delegated to nurses—the doing of dressings, the administration of medicines and physical therapy. Hospitals, too, have delegated authority and responsibilities to nurses in increasing degree. They are expected to keep records of patients' temperatures and pulse rates, they keep records of the patients' condition — much more detailed records of the small important things than, unfortunately, many doctors keep — and thirdly there are occasions when nurses, as a result of the knowledge and training they have received, do things which to them seem necessary without orders. In other words they exercise their own professional judgment.

Thus, you see, a nurse — every nurse — is something of a Pooh-Bah. She may be, in a legal sense, the servant of the doctor; she may be the servant of the hospital, or again she may be responsible only to herself for the exercise of her professional judgment.

Perhaps we can dig a little deeper, define a little more precisely. What are the duties of the nurse when she is the servant of the doctor? It would seem reasonable, and it is true, that her duties are to carry out his orders. Granted she does that and does it properly, her responsibility is discharged. Any error or unfortunate result following is the responsibility of the doctor. If, however, the nurse does not carry out the order properly and an unexpected result follows, the responsibility is hers. For example, a patient has a pain which the doctor thinks may be relieved by the application of heat in the form of a hot water bottle, which he requests the nurse to apply. The application of the hot water bottle is not the whole story. True, unless she carries out the order she is remiss and may be penalized, but as well, she has been taught the proper temperature at which to have the water in the bottle, and even if she follows out the order she is remiss if she uses water so hot it burns the patient. By custom — precedent if you like — it has come to be accepted that the doctor need not say "apply a hot water bottle at such and such a temperature". He expects the nurse, as a result of her training, to know the proper temperature. She, not the doctor, will be penalized if an error is made and the patient burned.

There is an exception to the general rule that a nurse escapes responsibility if she follows a doctor's orders. If an order is recognized by a nurse, or ought to be recognized by her as unusual or incorrect, and if she carries it out without confirming it, she may have to share responsibility with the doctor for any untoward results.

A similar state of affairs exists when legally the nurse is the servant of the hospital. Some duties are expressly laid upon her by the hospital and if she fulfils these competently, her responsibility is

ended. Any error or unfortunate result following therefrom is the responsibility of the hospital. But if the nurse fulfils the orders carelessly and harm results, hers is the fault.

Third and last is the most difficult to discuss — the occasions when nurses exercise their own professional judgment. So many things must be considered that we had better enumerate a few of them. It goes without saying that the individual holding herself out as a nurse must have had nursing training. It would seem equally evident, but unfortunately is ignored all too often, that she must have kept abreast of the advances in medical science. No nurse, for example, can nurse intelligently a severe diabetic who does not know something of the action of the various kinds of insulin, when their actions are exerted, what the times are of reactions to different kinds of insulin. Similarly no nurse fulfils her duty to a surgical case who has not learned the complications to be watched for and the new nursing procedures that will speed recovery. Then, the nurse must apply her knowledge in a careful fashion, "with due care and skill". If she fails to exercise due care and skill, she is guilty of negligence. Negligence is such a relative matter, so inclusive and so varied in its meaning, that the law has a general description which may be applied to particular cases. Mr. Justice Wills, about 1865 or 1870, said, "Negligence is the absence of care according to the circumstances", and any comment on that definition is sheer redundancy. As Mr. Newcombe said, "It reminds us that there is no absolute or intrinsic negligence; it is always relative to some circumstance of time, place or person."

When trouble arises for the nurse in any given case this knowledge lets us surmise the grounds on which she will be judged. Irrespective of the cause of the nurse's failure, whether the usual signs were masked by something else, or there was an atypical response, or the nurse had insufficient knowledge, the points at issue would be how much the nurse should have been expected to know, how much she did know, and whether she used due care and skill in applying her knowledge. They are nice points. How can anyone decide whether another knows enough and applies her knowledge sensibly? Reasoning by analogy from comparable situations where doctors have been involved, I will venture an opinion that I think is reasonable. In the case of doctors the law says their knowledge and skill must be that of the average of other doctors in the same district doing the same type of work — "the average standard of competent men in the circumstances in which he or she is placed". So it is probable a court would apply this principle to a given case and endeavour to learn whether or not the nurse had average knowledge and applied it as skilfully as the average competent nurse would have done. The answer to that question would help a court decide whether the nurse was guilty or was not guilty of negligence or malpractice.

Many of us, in our fear of the law, fail to remember that while it is stern it is also reasonable and was designed to govern the conduct not solely of the brilliant — or the stupid — but of average individuals. It by no means demands perfection under all circumstances. Ill results may attend a person's best efforts and this in medical practice as in other things. The law recognizes this and as long as it can be shown that the individual's best efforts were put forth, no penalty will be imposed. It has been said this way, "where an operation to be performed is complicated and difficult, a doer may err and be unsuccessful, and yet not be responsible if he or she fairly exert the best of his or her judgment". This is extremely important and remains important although modified by the fact that the "doer" must have adequate knowledge and must have kept that knowledge up to date.

Other factors arise constantly which

modify a nurse's responsibility. Consideration has to be given to the nurse's training, whether it was adequate or inadequate, in relation to the duty she accepted. That is, had the nurse any right to accept responsibility under the circumstances, or should she, in terms of her training, have refused? Then, too, should she have been asked to perform the duty? That brings us to another question. No doctor or institution should ask a nurse to perform an act for which, reasonably, she could not be expected to have sufficient knowledge or training unless the doctor or institution is willing to accept responsibility for the work done. These things the nurse must weigh in her own mind after which she must accept or refuse the request.

An interesting point with respect to nurses relates to breach of professional confidence. Where doctors are concerned, professional confidence must be maintained and the law provides protection for the doctor so doing. In the case of nurses professional confidence is a matter of ethics rather than law. Certainly the nurse should respect the confidence of her patients but the legal compulsion differs from that exerted on doctors. If the nurse does not and as a result of her talk harm to the patient is alleged, she may be held responsible for her utterances just as any other individual is. The patient may sue and if he proves his point it is probable judgment would be given against the nurse. Because nurses' opportunities for learning more things which should be held in confidence are greater than those of other individuals, their danger from loose talk is greater and it behooves them to be circumspect about professional matters.

Many of the applications of the law to present-day things, to the things nurses are doing, for example, during the present emergency which properly are not nursing duties, or at least have never been regarded as such in the past, I have left till the last for discussion. I am aware of your interest in them and it is only my own inability to deal with them specifically that makes me want to avoid them. Should nurses give intramuscular injections? do intravenous work? give anesthetics? One general answer may be given. If the training received by the nurse included the procedure and if she can demonstrate her fitness to do the work as a result of her training, then by all means do it. If on the other hand her training did not include the procedure and such knowledge as she possesses has been gleaned haphazardly, then by all means refuse to do it. But you say, this is an emergency, internes are few, doctors are busier and the need is great. Well, just remember that unless a doctor or a hospital will stand behind you in the event of trouble the load will be yours alone. You have no other protection. The burden of proof will be upon you to show that you possessed the necessary skill.

Let me digress a moment to impress on you the significance of that statement "the burden of proof will be upon you to show that you possessed the necessary skill". Under ordinary circumstances, that is, if a nurse is charged with failing in something for which she was properly trained, it is incumbent on the plaintiff to demonstrate beyond reasonable doubt wherein the nurse failed. Sometimes this is difficult to do and the defence is relatively easier. If, however, the nurse did something for which she was not trained, then a plaintiff would need merely to state this and immediately to win her case the nurse would have to demonstrate beyond reasonable doubt that her training or experience was sufficient. This is much more difficult. Stop for a moment and think how much more difficult it would be to win a case by proving that a nurse knew how to give a hypodermic than it would be to win by forcing someone else to prove she did not know how to give it.

Another digression by way of explanation. One of my duties is to advise doctors how best to avoid some le-

gal troubles. There are at least two ways to advise them. The doctors may be told just how close they can come to breaking the law without actually doing it, or they may be advised what course of action will follow the spirit as well as the letter of the law, and so be well within its provisions and therefore safe. This latter is the only prudent course, the only safe course. It is the reason for this advice to you.

In general nurses do not receive training for any of these procedures. It might be very difficult or impossible for a nurse to prove that she, as an individual, had had adequate training and had acquired the ability to perform them. Failing such proof, whether or not an ill result were due to something beyond the nurse's control, her position would be difficult and it is likely she would be penalized. Therefore do not do these things. It may be difficult to refuse but you have the example of one of the great nursing organizations in Canada to encourage you. It is my understanding that the Victorian Order of Nurses does not allow its nurses to do intramuscular and intravenous procedures, and in general for the reasons I have given.

There is one other piece of advice that is of value now and probably will become of increasing value. While nurses seldom are sued alone, they are being implicated in increasing numbers in suits directed primarily against doctors or hospitals. It is all too common to learn that nurses are without any financial help in the conduct of their defence. Malpractice insurance is available and can be taken out. The actual cost is comparatively little and is well worth while. It is seldom that one can defend oneself against a charge of malpractice or negligence at a cost less than several thousand dollars. That figure may be revised downward if the case does not get to court, and many do not, but it would certainly have to be revised upwards if the trial were a long one. Considering the number of nurses and doctors, suits against them are rare, but for the individual in trouble, without financial backing, that fact is of little comfort — while an insurance policy giving protection against the costs of a malpractice action is of great comfort.

Coagulation and Thrombosis

JOSHUA J. CHESNIE, M.D.,

Coagulation and thrombosis are two different processes although the basic elements in their formation are the same. Coagulation of blood is a process which takes place after blood has been removed from the body. It also occurs within the body after death. Thrombosis, however, is an active process which may develop in the living body while the blood is circulating, and cannot occur following death. The theory of clotting or coagulation which follows is known as *Howell's Theory*, although further work has been done which has upset many of Howell's concepts.

When an injury is received and blood is shed, a solid clot composed of a network of fibrin threads is formed. The protein fibrinogen of the plasma is converted to insoluble fibrin by a ferment called *Thrombin* which in turn is formed by the interaction of calcium salts with prothrombin. You may ask, why

doesn't all this occur constantly since the blood contains ionized calcium? This interaction is prevented by an anti-prothrombin in the blood called *Heparin*. The anti-prothrombin and prothrombin are in such balance that if some thrombin is formed in the blood, it is immediately neutralized by the anti-prothrombin. However, when an injury occurs, a substance is liberated from the injured tissues or from the platelets of the blood itself, which is called *Thromboplastin*. This substance neutralizes the anti-prothrombin thus allowing clotting to take place at the site of injury.

Why is coagulation so important and why are we so interested in coagulation and prothrombin time? What does this all mean? Obviously, intravascular clotting in a living person is not desirable but clotting at the site of injury is not only desirable but very important. If clotting time is increased, that is, if it takes longer than normal for blood to clot, then the individual may lose a great deal of blood and such loss may even prove fatal. As we have seen, prothrombin is necessary before the clotting process takes place. We can determine by checking the prothrombin time whether or not the individual has a normal quantity of prothrombin, or is manufacturing the desired amount.

It has been found by different workers that prothrombin is manufactured in the liver. It has also been discovered that vitamin K is necessary for the manufacture of prothrombin. In obstructive jaundice the prothrombin concentration of the blood is depressed because of failure to absorb vitamin K from the intestine; vitamin K is a fat soluble vitamin and, due to the absence of bile secretion, the fat is not absorbed. You can see how important it is to know the coagulation and prothrombin time in a patient with obstructive jaundice due to a stone in the common bile duct, for example, upon whom surgery is contemplated. With these people, the use of vitamin K is a lift-saving measure.

Before I go on to discuss the use of vitamin K, there are several conditions associated with decreased coagulability of the blood which should be noted, the most outstanding of which is hemophilia. In this disease, the females are not affected but they transmit the disease to the males who are called "bleeders". The essential defect in this disease is a deficiency of a coagulant which Howell believes to be thromboplastin. Another disease is purpura hemorrhagica which is associated with a great reduction in platelets and, as a result, a decrease in thromboplastin. Frequently, splenectomy is followed by an increase in platelets and quite often a cure.

Vitamin K is known as the anti-hemorrhagic or coagulation vitamin. Its importance pre-operatively has been mentioned. It is well represented in the foods we eat as, for example, cereals, carrots, yeast and wheat germ. It is a substance that can now be made synthetically. Its use in pediatrics and obstetrics is so important that its routine use as a prophylactic has not only reduced the incidence of cerebral hemorrhage in the newborn but has altered the clinical picture to some extent, symptoms of late bleeding being practically eliminated.

Low prothrombin in the newborn results from failure of the fetus to receive sufficient vitamin K, in utero. The administration of the vitamin to the mother, even an hour or two before delivery, increases the child's prothrombin enough to protect it from hemorrhage. As a result hemorrhagic disease of the newborn should now be regarded as preventable. Even if it has been neglected before delivery, infants' prothrombin time can usually be raised sufficiently to arrest bleeding within two hours by means of vitamin K.

Now, a few words about thrombosis. Where a clot is composed mainly of fibrin, a thrombus has as its chief constituent the platelets, although fibrin is associated with the thrombus. For a thrombus to form, the blood must be

moving. The situation in which thrombosis is of most importance to you in the nursing profession is when a thrombus forms in a patient convalescing from an operation or from a debilitating illness. There is nothing more heartbreaking to both doctor and nurse than to see a patient, who is apparently on the road to recovery, abruptly keel over with a cry of pain, have a sudden onset of pallor and sweating, and in a few moments breathe his last.

There are many reasons for thrombosis. I will mention a few, but the one I am going to emphasize is post-operative thrombosis, where the circulation becomes sluggish due to weakened heart action. This may occur in any vein in the body but the most important and frequent site is in the femoral vein, especially following an operation on the abdominal or pelvic organs. Several factors are involved in this formation. The retardation of the blood stream permits the platelets, which are the lightest cells in the blood, to settle out at the periphery of the stream and adhere to the wall of the blood vessel. Thromboplastin is liberated and, ultimately, fibrin threads are formed which entangle the white and red cells. After an operation, also, platelets are increased in number and show a greater tendency to clump together. The platelets accumulate on the walls of the veins and form ribs or beams which attract more and more platelets forming a spongy mass in the stream. The leukocytes, due to their lower specific gravity, separate from the red blood cells and adhere around this mass thus eventually blocking off the vessel.

To prevent post-operative thrombosis certain measures must be taken: the respirations of the patient are stimulated. Early and frequent movement of the limbs is encouraged. Anti-coagulants, such as heparin or dicumeral, are indicated for patients who have had pulmonary embolism and pulmonary infarction. Thrombosis may occur in the blood vessels due to inflammation and trauma but I have emphasized post-operative thrombosis because careful and intelligent nursing procedure contributes to its prevention.

In these days of war and speeded-up industrial activity the use of blood and plasma as life-saving measures is much to the fore and every citizen is very aware of their use. Many substitutes have been used to make up the loss of blood due to hemorrhage but the ideal replacement is blood itself. In certain conditions, such as burns, plasma is extremely valuable. On the battlefield actual, blood is not available so that plasma has to be used as an emergency measure. That is why the development of *dried plasma* is such a great step forward in war medicine and surgery.

As you may know, not everyone can give blood to everyone else. Every person is in a definite blood group. There are four major groups and, using the international classificiation which is the one most universally used at the present time, they are: O, A, B, and AB.

The three workers who were most responsible for classifying blood like that were Landsteiner, Jansky and Moss at the beginning of this century. It was quite a while before methods for transfusing blood were developed. Anastomosing a vein of the recipient (patient) with an artery of the donor was tried first; then the plan of using a surgical team was developed, one drawing the blood by syringe and the other giving it to the recipient. Nothing was added as an anti-coagulant since the blood was given before it had time to coagulate. At the present time with the development of blood banks and methods of indirect transfusion, a glucose citrate solution is being used as an anti-coagulant.

Why has the blood been placed in four separate groups? Blood plasma or serum contain substances which are capable of agglutinating red blood cells. These substances, called *agglutinins*, are thought to be attached to the globulin

fraction of the serum. The red cells may or may not contain substances which are capable of uniting with the agglutinins called *agglutinogens;* so the red cells may have A agglutinogens or B agglutinogens or both AB agglutinogens or neither A nor B agglutinogens, thus giving us O agglutinogens.

It has been found that if the blood has A agglutinogens and α anti-agglutinogens — the anti-A agglutinogens— the blood will agglutinate in the blood vessels. The agglutinin or anti-agglutinogens in type A blood is β agglutinin or anti-B agglutinogen. AB blood has O agglutinin and type O blood has both α β agglutinins. Why this should be is not known. To put it down briefly the groups go like this:

Agglutinogens	O α β	agglutinins
Agglutinogens	A β	agglutinins
Agglutinogens	B α	agglutinins
Agglutinogens	A B o	agglutinins

You see why group A cannot receive group B blood and vice versa — because the α or anti-A agglutinins would cause agglutination of the red cells in the recipient.

Group AB is known as the universal *recipient* since, when transfused by any other group, the cells of the recipient do not agglutinate. Group O is known as the universal donor since its serum usually does not affect the cells of the recipient.

In recent years, further study has revealed that there is more to the story of transfusion than this simple explanation would indicate. In a great many cases when groups of the same type were crossed they were found to be incompatible. The reason is that sub-groups and other factors in the red cells have been discovered, such as, the Rh factor, A_1 and A_2 sub-groups, the M and N agglutinogens, the P factor and the H factor. They all may be in the blood at the same time or they may be absent without relationship to other agglutinogens which may be present.

This additional knowledge is important where repeated transfusions are given to a recipient because he may develop agglutinins to an anti-agglutinogen of the donor's blood — M and N in the human is not one of these but the Rh factor is. The Rh factor or agglutinogen is of particular significance. Awareness of it explains a lot that has occurred in transfusion reactions, particularly in obstetrics and pediatrics, in compatible groups where the donor was the husband.

The Rh factor was discovered when workers Landsteiner and Wiener injected red cells of the Macacus Rhesus monkey into rabbits and guinea pigs producing an anti-monkey (anti-Rh) serum which was able to agglutinate the red cells in the rhesus monkey. It was found that the serum of 85 per cent of humans was able to do the same thing. These people, or rather, their blood, came to be known as Rh (after the rhesus monkey) positive. Those 15 per cent whose blood could not do this were known as Rh negative.

Levine found that the transfusion reactions occurred in women in childbirth, after having been transfused with the husband's blood due to the fact that the women were Rh negative whereas the husbands were Rh positive. The reason for this reaction is that the Rh factor is a hereditary dominant. If the fetus is Rh positive the Rh factor, which can be transmitted per placenta, caused the anti-Rh factor to be developed in the mother's circulation. If a transfusion is required by the mother, and it happens that the blood she receives is Rh positive, then agglutination with the donor's cells will take place resulting often in a fatal reaction.

There is a disease of the new-born known as acute hemolytic anemia or *erythroblastosis fetalis* which usually ends fatally. It has been found that these babies are Rh positive, the mother Rh negative, and the father Rh positive. In this case, the mother has developed anti-Rh agglutinins, as mentioned above,

and these have passed back through the placental circulation and have reacted with the red cells of the infant to produce this fatal condition.

In passing, I will mention cold hemagglutinins. These are present in people who, when exposed to cold weather, may develop hemoglobinuria, acute hemolytic anemia, or blueness of the extremities due to agglutination and resulting hemolysis of his own red cells. It has been found to develop after an attack of primary atypical pneumonia and may last for years.

Transfusion, as you can see, is a very serious and very important procedure. In transfusing a patient, the blood must be carefully typed and carefully cross-matched. False negatives and false tests may be obtained because of the cold agglutinins and other factors in the mind and checked because a transfusion blood. All these things must be kept in reaction is always serious and sometimes fatal. Once the blood is in, it is in, and cannot be removed. The recipient should be carefully watched and if he has any complaints of chills, pain in back or flanks, pain down the legs, a feeling of pressure in the chest, or even a feeling of anxiety that he didn't have before the transfusion was started it should be stopped. These symptoms are a sign of intravascular agglutination. Reactions can be treated but with not so much success if they are severe. Fluid should be forced by mouth and parenterally but the best treatment is prevention.

In conclusion, may I say that I have given just a bare outline of a subject that is of extreme interest and importance. I hope that it will stimulate you to read further on what has been left unsaid here.

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Daily Prothrombin Tests in Dicumarol Therapy

LILLIAN E. MARTIN

The increasing use of an anticoagulant to reduce the prothrombin level of the blood and so reduce the chance of clotting has been of much value in preventing such accidents as thrombosis, pulmonary embolism and certain venous thrombotic states.

The most common hemorrhagic agent in use is heparin which, owing to the difficulty of purifying and the necessity for continuous or repeated intravenous administration, has proven very costly. A substitute for heparin, which could be used for clinical application as an anticoagulant, has been developed, based on independent studies by Schofield of Canada and Roderick of the United States which revealed that the eating of spoiled sweet clover caused hemorrhagic disease in cattle. In 1941 Professor Paul Link and his associates of the University of Wisconsin isolated and crystallized the active principle that was responsible for this condition, namely "Dicoumarin". Since then a series of brilliant investigations by Meyer of the University of Wisconsin and Butt and Allen of the Mayo Clinic have resulted

in the discovery of a synthetic compound that is identical in biologic characteristics, namely "Dicumarol".

During experiments the following tests were done on individuals, both before and after the administration of therapeutic doses of Dicumarol: red blood count, white blood count, urinalysis, blood sugar, N.P.N., creatinine, liver function, icterus index, serum calcium, bilirubin, renal function, blood platelet count. No pathological changes were found in these tests, but there was some question of increase in the sedimentation rate.

Dicumarol is administered by mouth in gelatine capsules since soluble salts for intravenous use have not been found to be stable. The administration of Dicumarol has not been attended by any symptoms of toxicity other than hemorrhage, which probably resulted from an overdose. Following administration of Dicumarol, regardless of the size of dose, there is always a latent peroid of twenty-four hours, sometimes forty-eight hours or even as long as seventy-two hours, before the reaction on prothrombin time is apparent. Depending on the duration of therapy, and to some extent on the total dose, the time required for a return to normal may be two to ten days and is usually five to six days.

During Dicumarol therapy, frequent urinalyses should be done to detect hematuria. If the operation is on the gastro-intestinal tract the stool should be checked for blood. No two patients react alike; some bleed when the prothrombin time is increased five times, while others can go as high as ten times.

Daily Prothrombin Time Estimations Must be Done

Vitamin K in ordinary doses has not as yet been shown to be an antidote in combating increased prothrombin time resulting from Dicumarol therapy. Transfusions of fresh whole blood, fresh citrated blood or fresh plasma should be given and, as the result may be only temporary, repeated transfusions may be indicated. It has been proven that the prothrombin concentration of stored blood or plasma falls rapidly with age. After the latent period there is a gradual increase in prothrombin time until the maximum is reached, usually three to five days. Administration should always be controlled by daily prothrombin time tests. The Magath modification of Quick's method is advised.

Dicumarol Therapy

This test is very delicately balanced and correct technique is of the greatest importance. The exact mode of action of Dicumarol is not known. One theory is that some action within the body is necessary for it to be effective, as it has been proven that Dicumarol added to blood in vitro does not affect the prothrombin concentration. It is assumed that Dicumarol acts on the liver and retards prothrombin production. After the prothrombin present in the blood at the time of administration of Dicumarol is used up, there is a noticeable prolongation of prothrombin time — this explains the latent period of twenty-four hours or more.

Dosage:

At the Mayo Clinic dosage is based on the following suggestions: If the normal prothrombin time is eighteen to twenty-two seconds, Dicumarol is administered to produce and maintain a prothrombin time of twenty-five to sixty seconds. The physician in charge must individualize the dosage on the basis of the clinical condition of the patient and on the laboratory findings. Prothrombin time estimation is always checked before the administration of Dicumarol. They suggest that the total daily dose be given at one time after the prothrombin time for that day has been determined, remembering that all patients do not react alike. Like the Mayo Clinic, Wright and Prandoni of the New York Post-Graduate School of Medicine, suggest

using a small initial dose, with larger doses to follow being determined by prothrombin time estimations. Contrary to this, Meyer, Bingham and their associates of Wisconsin recommend a larger initial dose followed by daily smaller doses.

Practical, safe and effective dosage appears to be based on giving 5 mgm. per kilogram of body weight for the initial dose, and controlling subsequent doses by daily prothrombin time estimations.

It must always be borne in mind that there is a latent period of at least twenty-four hours *after* administration. If immediate effect on blood coagulation is desired, heparin may be given and Dicumarol started at the same time. Heparin will not affect prothrombin time but will affect blood coagulation at once. It may be given for twenty-four to seventy-two hours.

Administration:

Dicumarol may be given to patients on sulphathiazole or sulphadiazine therapy without ill effects. Dicumarol may be used as a prophylactic on patients having a succession of surgical procedures or if there is a history of intravascular clotting. It is necessary, however, between operations, to allow the prothrombin time to come back to normal. Dicumarol should never be given to patients with prolonged prothrombin time (unless, of course, previous administration has caused it). It should never be given to patients bleeding from any cause or purpura of any type. It should never be used if there is an ulcerating or granulomatous lesion. It seems to cause definite hazards if administered to those patients with sub-acute bacterial endocarditis. It is not advocated for use where patients have continuous tube drainage of the stomach or small intestine.

Dicumarol should be used with caution in the following cases:

1. Debilitated patients.
2. In the presence of liver or renal dysfunction, especially where there is jaundice, hepatic cirrhosis or enlargement of the liver.
3. During menstruation, menorrhagia or metrorrhagia.
4. To patients having surgery on the brain or spinal cord — chiefly because of the extreme danger of the results of hemorrhage.
5. Dicumarol has a tendency to have an increased effect on febrile patients or those taking salicylates or aspirin.

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Preview

While his paper on the early development of pediatrics as a specialty will be of greatest interest to [illegible]s in the province of Quebec, we felt that all of our readers would enjoy the account of it written by Dr. Harold B. Cushing, emeritus professor of pediatrics at McGill University.

Advisory Board on Nursing Education

The Council of the Royal College of Nursing has set up an advisory board on nursing education under the chairmanship of Sir Cyril Norwood, M.A., president, St. John's College, Oxford, with Miss E. E. P. MacManus, O.B.E., S.R.N., matron of Guy's Hospital, and chairman of the Education and Training sub-committee of the Nursing Reconstruction (Horder) Committee, as vice-chairman.

The object of the advisory board is to ensure that nursing education benefits by the advances in educational methods and facilities which are characteristic of present developments, and to enable all those participating in the post-certificate education of the nurse to obtain help and advice which is both educationally sound and professionally appropriate.

The personnel of the advisory board includes educationists representing the universities, general education and the medical and nursing professions.

Many factors have, in the last twenty years, brought into prominence the educational side of the training of the nurse. The introduction of State examinations for nurses in 1925, the development of post-certificate qualifications for sister tutors, health visitors, midwives, nurse administrators, ward sisters, industrial nurses and other nurse specialists in the inter-war period, and the recommendation of the Athlone Committee that pre-nursing courses be established in the schools, have all led to increased educational activity with the necessary integration of the profession and other educational authorities.

For instance, the schools, since July 1939, have begun to prepare nurses for their professional examinations in anatomy, physiology and hygiene, and the nursing and medical professions continue the education of candidates during their period of training. Universities, colleges and polytechnics have helped to promote post-certificate nursing education.

Before the war twelve to fifteen thousand girls entered the nursing profession for training on an average annually, and the number has now increased. Between nine and ten thousand of these enter for the preliminary and final state examinations and from six to seven thousand qualify as State registered nurses each year. In addition an increasing number of nurses take post-certificate courses to qualify for the many fields of work now open to State registered nurses; the College itself has over one hundred post-certificate students at the moment at headquarters alone. The total extent of the educational work involved is great; in comparison four thousand women supplemented by two thousand men teachers were trained on an average each year before the war.

It is obvious that there must be close links between the nursing profession and educationists generally, especially since the Education Act will raise the school-leaving age and increase the facilities for vocational training for such professions as nursing in the schools, and because refresher and post-certificate qualifications will be in increasing demand as the national health service becomes established and the recommendations of the Rushcliffe Committee become effective.

The Council hopes that this Advisory Board will help to further these links, and will enable the College of Nursing to carry out more fully the articles of its Royal Charter, which give it the power "to promote the science and art of nursing and the better education and training of nurses", and the right to "institute and conduct examinations in all branches of women's work conducive to the efficient conduct of the nursing profession, and to grant certificates and diplomas to those who pass prescribed examinations" and "to provide, establish and maintain offices, examination halls and lecture rooms for courses of lectures and demonstrations" for the nursing profession.

Preview

What do you know about the International Council of Nurses? How did it get started? What are the plans for reviving its activities in the post-war world? Because there are so many of the newer graduates who are unfamiliar with the International organization we asked Grace M. Fairley, who is third vice-president, to prepare a brief outline of its history and development.

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses Association

Adult Behaviour in Relation to Supervision in Public Health Nursing

MILDRED I. WALKER

In the evaluation of the public health nurse much stress has been placed on certain personality traits such as tact, poise, initiative, ability to get along with people. It was very pleasant to recommend a nurse with such traits. However, these were not related to the total situation so did not mean much. It is realized now that personality traits must not be isolated but must be considered in relation to the total situation. Certain standards of adult behaviour have been evolved and an adequate program of supervision in the field of public health nursing might well be built around these recognized criteria. They should be applied alike to the administrator, the supervisor, and the nurses who participate in giving guidance to the families and the individuals in their community.

Emotional adulthood does not just happen, it must be developed. With the stresses and strains of life we may not remain at the adult level so those who guide others must be aware of the characteristics to be expected so that they may point the way to emotional adulthood. The more often we react in an adult manner, the more definitely the pattern is established and the easier it will be to respond satisfactorily. Intellect, *per se*, is not a guarantee for a happy life any more than physical build or great possessions. It is the co-ordination and integration of the physical, mental, emotional and social traits of the individual which produces or releases a wholesome personality.

When intellect and soma (body) are both normal, two factors for satisfactory living are present. A third essential is fullness of emotional development or adulthood. Intellectually, the adequate adult arrives at her own opinions and follows her own conclusions in handling life's difficulties. She does not seek counsel indiscriminately and is not at the mercy of suggestions which come from the people about her. Therefore, she is not dependent upon constant advice or admonition. She selects all the factors in the given situation, she weighs them or evaluates all their relationships and decides what is best to be done, then she acts, and accepts the responsibility for her action.

CHARACTERISTICS OF EMOTIONAL ADULTHOOD:

1. *Ability to adjust at the social level*: She is able to get along with people. She has the ability to adapt satisfactorily to new situations but her adaptability must be evaluated on the level of her edu-

cation and experience or her social (professional) level.

The negative aspect is shown by one who (1) cannot carry responsibility; (2) has not learned to renounce; (3) withdraws from society because of shyness, lack of social interest, sense of inferiority; (4) has to be handled with gloves on; (5) cannot co-operate but always dictates (creates authoritarian social climate in an executive position); (6) feels the world owes her a living; (7) takes unfair advantage of others; (8) goes about with a chip on her shoulder; (9) cannot bear to postpone pleasure—unable to delay responses; (10) draws on sympathy of others, self-pity (poor-me attitude); (11) requires coddling; (12) is a parasite (unable to sustain herself physically or wait upon herself).

2. *Emancipation from the parental roof* including parents or any compulsive form of authority. This does not entail being belligerent or over-submissive towards parental ties but should enable the individual to graduate from infantile meekness and acceptance to the ability to make her own adjustments. "Peace at all cost" is not always adjustment on an adult level. Just as the kite rises against the wind so is a certain amount of opposition a good thing. It can be accepted as a challenge to better performance. Concentration of responsibility in one person is not a concentration of authority. It is the establishment of leadership. The true leader will encourage self-dependence and thinking in her guidance.

3. *Full heterosexuality*: One must learn to work with the opposite sex with equal objectivity and friendliness. This is one of the most important aspects of adulthood. The negative reaction is an infantile or adolescent tendency to cling to an immature type of behaviour: (1) to take childish pride in being a spinster; (2) to take a thin-lipped and prudish attitude towards the natural functions. People often manifest unlovely psychological representations in some departments of their own lives; (3) to show intolerance, smug complacency, obsession for orderliness, over-meticulousness about dress, miserliness, and in general an insurmountable parsimony in giving of themselves generously to society.

4. *A satisfying philosophy of life*: We must work out for ourselves some system of ideas that will reconcile us to having been born. We must be purposeful, and set up a satisfactory philosophy of life. The reverse side of the picture shows such negative responses as: (1)

For many —

Life is a place
Where we dig in the ditch
To get money enough
To buy food enough
To get strength enough
To dig in the ditch

(2) Infantile philosophy which says, "In so much as I was not consulted about being born, I take no responsibility and I mean to get as much out of life and give as little in return as possible". One's reward in life is according to the contribution one makes. In the family, we are accepted as a personality, as a part of a whole, but we are accepted in society for the contribution we make towards our work group and play group.

(3) Problems presented are so vast, that it is futile to make an effort. This happens in public health nursing where the policies are not well defined or where too much is expected of one nurse in a community or a district program where her case load is too heavy. Point out here that there is never a final "end result". The goal when reached becomes a means to an end. Life is an ongoing activity and our philosophy must be attuned to growth.

What to do About It:

Evaluate the whole situation. If we hitch our wagon to a star let us make the goal attainable, that is, within our capacities. Our philosophy of life is not a garment but a part of the fabric of our exis-

tences. It will assist us to adjust and adapt to new situations. Our philosophy must have no finalities. Our emotional health represents our achievement of "at homeness" and of peace with the people in our universe. It means that we recognize ourselves as an integral part of society and that in considering the welfare of society we thereby advance our own. It means we recognize the unity of rights and obligations; that there can be no rights without comparable obligations. With responsibility comes freedom but also with freedom comes responsibility.

Therefore, in the evaluation of the individual in public health nursing, relate her total personality and her performance to the total situation thus avoiding the outmoded emphasis on isolated personality traits, unrelated to the situation under consideration. If the individual shows characteristics which are not on the adult level, seek out the reasons and guide her to raise her levels of effectiveness to the adult behaviour pattern. There may be some abnormal conditions of which the supervisor is not aware, but which if known, could be ameliorated. Also there are persistent problems for which there is no solution and this must be accepted. Thus, the individual may be assisted to improve her performance through the development of a wholesome personality which is a subtle but forceful influence in creating the democratic social climate essential for healthful living.

The Value of Mental Hygiene in the School

SELENA HENDERSON

Mental health should be thought of as a part of general health. The nervous system is one part of the person. While it is one part of a whole it is so closely integrated that it cannot be separated except for purposes of discussion. The nervous system plays the prominent role in forming those connections between the individual and his environment which will enable him successfully to adjust himself to his environment. So we may say then, that the unadjusted person is one whose habits and skills are inadequate to meet the demands of the situation or who lacks the ability to solve the problems which are met in the course of everyday living. On every side we see them. They are the timid and retiring, the bullies and tyrants, the delinquents and criminals.

The mental hygienist points out that behaviour is the result of a cause, that misconduct is a symptom, and seeks to understand the underlying motive for conduct and to effect a rearrangement of the irritating situation with the result that the misconduct vanishes. Up to the present mental hygiene has devoted its attention to the remedial treatment of the problem child and it is of this phase of the work we will speak. Nevertheless the day is approaching when mental hygiene will be the guide in all the human relations of the school; when the teacher in the classroom will have learned to interpret behaviour in terms of the drives which it satisfies and the thwartings for which it compensates rather than in terms of laziness, stubborness, obstinacy or stupidity.

Mental hygiene has been established in the schools of the larger cities of Canada for some years. In the United States it has progressed far in advance of Canada and medical-social set-ups which include psychiatric service are found in all the larger schools widespread across the country.

What is the procedure in our work in the schools of Montreal? As stated before, at present we deal for the most part with the problem child. Who is the problem child? From the point of view of the school he is the child who repeats a grade, is a chronic repeater or presents a behaviour problem.

Our procedure in the attempt to solve these problems is:

1. The administration of tests: (a) physical, to look for physical weaknesses or defects; (b) intelligence, to determine the general intelligence level of the pupil.

2. The interview with the pupil himself covering his reactions toward school, the conditions of his daily life, his ambitions and plans, his tastes and interests, activities, companions, attitude toward members of his family and so on.

3. The visit to the home in order to understand the home influences surrounding each child and to attempt to influence the parents to make whatever adjustments are necessary.

The test used for the most part in ascertaining the I.Q. (Intelligence Quotient) is the Binet-Simon, Stanford Revision. This test has stood for years as the outstanding example of carefully and scientifically standardized tests. It is individual, taking about one hour. It is made up of an extended series of tests in the nature of problems, success in which demands the exercise of intelligence. The scales consist of fifty-four tests so graded in difficulty that the easiest lies well within the range of normal three-year-old children while the hardest tax the intelligence of the average adult. The problems are designed primarily to test native intelligence not school knowledge nor home training. It does not attempt to measure the entire mentality of the pupil nor to bring to light special talent.

For children who are mute, do not understand English or who may have more ability to deal with things than words the Pintner-Patterson test is used. This is a "performance test" using a form board with openings of various shapes cut out of it and blocks which must be fitted into those openings. A number of types of form boards are used.

What actually do we mean by an I.Q.? The intelligence quotient refers to the relation between the child's mental development and what we should expect of him at his chronological age. One is born with a certain mental capacity which does not alter appreciably throughout life.

The results of the Binet-Simon test are graded as follows:

Above 140, near genius or genius; 120 to 140, very superior intelligence; 110 to 120, superior intelligence; 90 to 110, normal or average intelligence; 80 to 90, dullness; 70 to 80, borderline deficiency; below 70, definite feeblemindedness; 60 or 70, mental debility superior type; 50 to 60, mental debility inferior type; 25 to 50, imbeciles; 25, idiots.

About 2 per cent of the children in a school have an I. Q. below seventy. The mental development of these children will stop somewhere between the seventh and twelfth year level, more often between the ninth and twelfth year level. They may drag along to the fourth, fifth, sixth grades but even by the age of sixteen to eighteen years they are never able to cope successfully with the more abstract and difficult part of the school course of study. These children constitute a large percentage of our problem children in the school. Therefore mental capacity having been ascertained by means of an intelligence test, placement in a special class solves many problems.

There are special classes in many of our Montreal schools. Here each child receives individual instruction progressing in proportion to his mental ability. Emphasis is placed on developing motor functions and placing children as much as possible in everyday life situations.

Along with it the fundamentals of simple academic subjects are taught and instruction given in acceptable moral and social attitudes and behaviour.

In one school in Montreal we have what we believe is unique in Canada, an opportunity class or rather two opportunity classes, one taking in grades three and four the other the older group grades five, six, and seven. The children in these classes have very superior intelligence. They also are given individual instruction. The idea is not to speed up but rather to broaden the curriculum by permitting the child to branch out into other subjects, do projects, and so forth, according to his aptitude and interests. Here again placement in the opportunity class often is the answer to a problem.

Problem-cases in the school range from simple ones which are quickly solved to most complicated and involved ones which require prolonged effort on the part of all concerned to bring about a satisfactory conclusion.

Sydney was a boy of thirteen and a half years, problem truancy. An intelligence test showed a mental age of eight years eleven months, an I.Q. of 66, mental debility superior type. A visit to the home disclosed he was the eldest of three boys, a shy under-sized lad with defective vision but who would not wear his glasses, and smaller than his brother who was a year younger. The home was a miserable one in a poor district although there was evidence of attempts on the part of the mother to keep it clean and home-like. The father had been in the army for two years, stationed away from home. The mother worked part-time in a restaurant to augment the family income. She was a loud-voiced, rather brazen woman but sincere in her desire to do her best for her family. She co-operated with us willingly and well. The brother was also tested and although he was found to be somewhat slow-minded, nevertheless he could do the work in an ordinary classroom. Sydney depended on his younger brother entirely and wanted to be put in the same room with him, but, he needed to go in the special class! Both boys were placed there though for John it was only temporarily until Sydney became adjusted to his new surroundings. This arrangement has worked satisfactorily and Sydney is now attending school regularly.

Patricia was six and a half years of age in the first grade. Although she attended school regularly she could not do any of the work of her grade. Her mother came to the school to inquire about her poor report expressing her belief that Pat could do the work but didn't, and that the fault lay with the teacher who not strict enough with the child. Pat's tests showed her to have a mental age of five years giving her an I.Q. of 78, borderline. At the teacher's request the mother obtained a morning off from the war plant where she worked in order to come to the school for an interview with the mental hygiene nurse. During the discussion it was learned that Patricia was very slow about carrying out directions and was nagged continually, not only by her mother (the father is overseas), but also by grandparents and uncle, with whom the family lived, for her "stupidity". Patricia, it was also discovered, was under the doctor's care for "nervousness". An explanation of Pat's mental ability was given to the mother and the harm this constant nagging was doing pointed out. Proper methods of handling the child were discussed. At the end of the conference the mother asked to speak to the teacher with whom she was able to talk over Pat's progress from a different and more amiable point of view, and finally agreed the wise course was to place Pat back in kindergarten.

A different problem was presented by Albert aged six years eleven months and in grade one. His teacher reported his school progress poor in spite of great effort on his part. A test revealed a mental age of seven years two months giving an I.Q. of 103.5, normal intelligence. A brief survey of this small, pale undernourished child showed that the main factor in his lack of progress was malnutrition. The case was turned over to the school nurse for intensive work with the mother in proper nutrition and child training.

Barbara aged eleven and a half years was in grade four. Her teacher reported that "the girl is always trying to copy from someone, not so much to cheat as that she realizes her own inability". Her test gave Barbara a mental ability of ten years seven months an I.Q. of 92, normal. She was a shy child, one of a family of eight children whose father was a labourer. She lacked

self-confidence to a marked degree and responded visibly to urging and encouragement. It was obvious that the reason she copied other children's work was that she had no faith in her own!

Corinne aged nine years ten months was also in grade four. This teacher reported "Corinne doesn't seem to be poor in any particular subject except arithmetic, but she does not co-operate in any subject nor lesson so fares badly at testing time. Her attitude is sullen. When going up to the blackboard she deliberately saunters. She laughs loudly and makes rude noises and when reprimanded becomes sullen and irritable. Her school attendance is irregular, no reason being given except that 'she doesn't feel like coming' ". Corinne's test showed a mental ability of nine years five months giving an I.Q. of 96, normal. She was a shy, deliberate child. Rapport established she co-operated willingly and well. But if she was hurried, the question just asked would leave her mind entirely. She presented a good example of "a feeling of inferiority and the unconscious attempt to compensate for it". This bidding for attention and noisiness was her method of compensating for her feeling of insufficiency. The teacher's attitude changed entirely after the cause was explained to her, and Corinne's response was good.

Blanche aged fourteen years was in grade seven and was doing very poor work. A test revealed a mental ability of ten years eleven months giving an I.Q. of 78, borderline. Her parents were planning on withdrawing her from school and sending her to business college. A visit disclosed a home in a poor neighbourhood, inadequately furnished but clean and home-like. The father was in the army, the mother working as a ward maid in a hospital. Blanche was the eldest of three girls. When the nurse arrived she was busily and happily preparing the supper, having completed the marketing. Blanche is a well-developed, rather attractive girl with a pleasant personality. When the mother arrived Blanche's future was discussed with the result that in view of her age she will repeat grade seven then go into service of some kind such as housework, cook, waitress or seamstress rather than waste time and money on a business course in which she would never make the grade.

It will be noted in the study of these cases that not all the remedial work is done by the mental hygienist. More often her task is to seek out the underlying causes of the misbehaviour, to make those concerned see the situation as it is and to enlist their aid in effecting an adjustment to a more favorable situation. The principles of mental hygiene should penetrate to every corner of the school, should permeate the whole educational system. The day is approaching when this will happen; when every teacher, as a part of her training, will be given a full understanding of the principles of mental hygiene. What a revolution this will bring about in our whole educational system! Even now the mental hygiene point of view with its emphasis on the attempts to effect adjustments is rapidly displacing the old ideas of discipline. Whereas formerly the formation of right habits of conduct and thinking were taken care of in the home and church, the complexity of our modern civilization has rendered this course no longer feasible. More and more these things are being left to those responsible for the child's education. And since the whole child comes to school and the school is responsible for the child as a whole why is not this in very truth the better way, providing the teachers are well-adjusted and adequately trained themselves? No longer can the school hope to remain a place where only academic subjects are taught but more and more it is becoming responsible for the formation of those right habits of behaviour and thinking which will produce well-adjusted individuals, able to fill happy and useful places in society. This is a protection not only for the individual but for society itself. Mental hygiene, theoretically a science, in reality in its everyday applications is an art, which like the little acorn will develop into the mighty oak — a tremendous weapon to influence the future generations of our nation.

HOSPITALS & SCHOOLS of NURSING

Contributed by Hospital and School of Nursing Section of the C. N. A.

Organization of the Hospital Nursing Staff

EDITH PRINGLE

Let us not dwell on the difficulties of the past few years in relation to nurse shortage and the many problems that ensued as a result but rather look forward and plan carefully for the future. The problem of stabilization of nursing service and the rehabilitation of nurses is one that will require the *best* we all have to give. Just as there have been gains and losses on the battlefields in Europe we have also made certain gains and also suffered losses in the civilian fields of nursing administration. The gains made now depend on leadership and direction. While it is difficult to organize a nursing staff without nurses, nevertheless we are not going to attract nurses or keep the ones we have unless there is sound organization within each and every hospital. The organization of a hospital depends very largely upon the administrator. To organize the nursing staff we require nurse administrators capable to giving leadership and direction. We are all interested in doing a better job. We are all agreed that to command or boss is not our aim but rather that we give leadership.

Within a hospital we are working as a group and without co-operation and co-ordination all is lost. How we can make this group activity a happy and, at the same time, a satisfying experience for those with whom we work is a question that we should all study. First, there must be centralization of authority. It takes special effort on the part of someone in the organization to tie the whole together and make each person feel related to the whole. Second, this central authority must be the co-ordinating force which provides administrative practices. The administrative or executive job requires a person gifted as a leader. The job itself includes: Planning and defining policies and procedures. Organizing the activities of others. Delegating authority and responsibility. General orders and instructing. It is a co-ordination of all the various efforts and includes the important task of stimulating and vitalizing all the individuals who are contributing their part. It consists of combining the human energies in a way that creates a new and satisfying harmony of effort, where indifference becomes conviction and inertia initiative. Passive consent gives way to active participation and new levels of attainment are reached.

More effective results are obtained by leadership than mere direction. It has been said, "To be properly led is a moral right. To lead properly is a moral responsibility". Organizations now command executive direction plus leadership. A leader requires energy, enthusiasm, friendliness, integrity, decisiveness and intelligence. The good leader is a good teacher. Good training can

largely take the place of order-giving *but* sound planning is required.

The job of a leader, a manager, an executive or a supervisor, is to get people to do more readily what they ought to do and to get them to enjoy doing it. Our value as a leader is based upon our capacity to accomplish just that; in other words, it is not the direction of things but the development of the people with whom we work. This calls for a perfect understanding between the various groups of workers and between the workers and their leaders. If we are to give the best care to patients and obtain the best results from our workers we must start from the foundation and build a solid structure. We must not however overlook the welfare of the worker. Without proper working conditions we cannot hope to attract the type of women we desire in the nursing profession nor, alternatively, can we keep nurses in the nursing profession.

A nurse may do an excellent piece of work in one hospital and fail hopelessly in another. This failure may be due to lack of direction or to misunderstanding. Personnel work must of necessity be personal work if it is to be effective. There must be an intimate personal relationship between the management and the individual worker. Personal work cannot be just a mechanical procedure. It requires study, analysis and planning; not only analysis of the job and of the workers as individuals but a lot of self-analysis on the part of the administrator or supervisor.

Are we giving what we should? Are we leaders? Do we try to do the job ourselves or do we delegate authority? Have we planned the job so that we know where we are going? Do we know how to organize the activities of others? Do we lead or do we drive? Have we a staff education program? Do we consider staff education as "in-service" training? Have we set out the policies and procedures in ward manuals for the guidance of our staff? Do we keep close to the workers? Do we avoid job irritants? Do we present the job to the worker in a fair and comprehensive manner? In other words do we really orient our workers? Have our nurses the proper equipment to carry out their service to patients? Do they receive adequate pay? Do they work longer hours than necessary and if so, do we know why? Do we really know how very necessary it is that employees are contented and feel that there are opportunities for development and advancement? Satisfactory working conditions oftentimes mean more to an employee than the salary.

Are we fair? Are we helpful? Are we inspiring? Do we confer with our workers? If so, are our conferences what they should be? Do we outline new policies at our conferences? Are they educational? Do all participate? Do we know how to give constructive criticism? Do we know how to deal with grievances?

Let us consider some of these points. What of staff education? To make a program for staff education function we must have a plan. The good sound plan requires study and hard work. To function successfully it requires working together. This includes the nurse administrator, the supervisors and staff nurses. Staff education should stimulate each and every nurse. Planning has been defined "as the best use of time and energy. It is the way in which the administrator knows what she is doing and what is taking place in the institution". It is a basic administrative principle in organizing and in supervision. To construct a plan we must analyze the situation. Study the findings — determine the needs — formulate a plan and put it into action. No plan remains static; it requires study for adjustment or re-building. In planning we must also evaluate. What are the results of the plan in terms of nursing service, the staff, and self? Is the staff co-operative and are they interested? What of

self — what have I learned — face up to failures, why do they occur, am I the reason or what?

Training does not stop with the acquiring of special skills. It must be extended to the development of the nurse as an individual, functioning unit of the organization. We must, therefore, bring into our staff education program an opportunity for continued growth, opportunities for advancement and recognitions for ability. The nurses should be made to feel they belong to the hospital staff and should feel secure. They expect protection and moral support. They should receive accurate knowledge regarding the hospital policies and procedures. It has been said: "Through group thinking members gain a perspective and a common understanding of aims, policies and methods of accomplishment in a way that is not possible for any one to secure alone. It develops a staff spirit".

How important, therefore, is the staff conference! To have a successful staff conference we should make adequate preparation and have a prepared agenda. All nurses should participate. Much valuable information can be given to staff members at the staff conferences, information regarding new policies, etc.

The chairman of the conference becomes the teacher who guides the procedure but does not dictate the end or solution. She must know all the ramifications to assist in guiding but not dictating. The nurse administrator should stand prepared to abide by the conclusions reached which represent the group, its knowledge and its purpose.

What type of staff conference do you have? What is the result? Do the nurses present their problems or do they consider the periods useless and a fag, or worse still just a time for someone to find fault with them. To my way of thinking the length of the conference is important. It can be too long.

Some questions we should ask ourselves could be as follows: Are we precise in outlining the particular point for discussion? Do we clarify meanings? Do we keep the meetings impersonal? Do we direct discussion toward a definite objective? Do we summarize the discussion in a helpful way? Do we sense when it is time to cut off discussion and formulate an integrated solution? Do we attempt to get out the deeper reasons behind superficially expressed differences?

Provincial Placement Service

ELIZABETH BRAUND

Some years ago nurses in Canada and the United States recognized a need for a professional Service or Bureau which would assist in solving the problems resulting from poor distribution of nurses, and lack of adequate counselling and guidance. In 1938, the Council of the Registered Nurses Association of British Columbia appointed a committee to study the whole situation with a view to setting up a Provincial Placement Service. War emphasized the need for such a Service and hastened the work of the committee.

At that time there were no nurse placement bureaux in operation in Canada and the ones which were functioning in the United States were planned to meet nursing conditions and requirements which were very different to those existing in British Columbia. The result was that the Committee had little which could be used as a pattern when they drew up the "Outline of the Functions of Placement Service". There is ample proof that exhaustive study was put into the outline. It was soon felt that some changes in it would make for smoother

running of Placement Service, but in the main the outline served as a good guide.

Another consideration which provoked considerable thought was that of financing the project. This too required much study. Finally a plan to increase the annual registration fee from two dollars to five dollars was adopted by the nurses at an annual meeting of the Registered Nurses Association of British Columbia. Two dollars of each fee was allocated to the financing of Placement Service. It was realized that this was an insufficient sum to meet the full cost of the undertaking and government grant funds were a welcomed supplement to the revenue. Thought is at present turned towards planning for a time when Federal Government Grant funds may not be available.

In April, 1943, the British Columbia Provincial Placement Service was established. To date only registered nurses and graduate nurses who are holding permits which allow them to practise their profession under the sponsorship of the Registered Nurses Association of British Columbia are placed by the Service. The machinery is available for the placement of subsidiary nursing groups but the Registered Nurses Association is not in a position to place them at present, although it is the intention of the Association to offer this service as soon as the way is clear.

Placement Service undertakes to place nurses in all branches of nursing. Placement of nurses, with the exception of private duty nurses and a limited number of nurses who are placed in temporary general staff positions, is the function of the Provincial Placement Service. Because private duty calls are received at any time during the twenty-four hours, Regional Branches of the Provincial Placement Service were organized in Vancouver and Victoria to facilitate the filling of such calls. Similar branches will be organized in other communities when the need for them is demonstrated.

After the outline of the functions of the Placement Service had been followed for a year, it became apparent that Placement Service would function more efficiently if there was some reorganization in the "Chain of Responsibility" and if the duties of the Provincial Placement Bureau Committee, the Advisory Board and personnel were more clearly defined. Since the new "Organization of Provincial Placement Service" may prove useful to those provinces which are in the process of forming a Bureau the plan is appended in its entirety.

The "Chain of Responsibility" can more clearly be understood if we study a problem which may arise in a Regional Branch. The director of the Regional Branch first undertakes to solve the difficulty. If she cannot do this she passes it on to the director of the Provincial Placement Service. If the latter requires advice she presents the problem to Provincial Placement Bureau Committee. In the event that a solution cannot be found and the community interest is involved or it is obvious that lay and professional advice outside of nursing would be beneficial it is referred to the Advisory Board, whose decision goes back to the Provincial Placement Bureau Committee. If further advice is necessary it is taken to the Council for discussion. In any event, all recommendations of the Provincial Placement Bureau Committee must be endorsed by the Council.

The present difficulties which are encountered should tend to become less as Placement Service gains the confidence of all employers and nurses who use the service. From the beginning we have been faced with an insufficient number of nurses to fill all vacancies. Not only is there a shortage of nurses but this is accentuated by the frequency with which many nurses change their positions. Since the use of Placement Service is entirely voluntary it is found that all nurses have not enrolled. This situation is gradually improving as nurses become accustomed to making use of the Service, and are acquainted with

many advantages which Placement Service offers. These include accurate and up-to-date lists of vacancies with details regarding the terms of employment. Other benefits which nurses receive come under the counselling portion of the Placement Service program and include guidance regarding the type of work for which the applicant's preparation, experience and ability best suit her, and suggestions for further post-graduate study to prepare her for future positions. Another advantage the nurse enjoys is the introduction she receives to the employer. This may take the form of an interview which has been arranged on her behalf or a letter addressed to the prospective employer giving her qualifications and places of past employment. After the nurse has personally experienced the many aspects of the Service it is usually found that she readily turns to Placement Service when she is again in need of help.

As the service is so new it has not always been easy to convince employers of the benefits of Placement Service. Once their confidence is gained we find them returning repeatedly for assistance. This statement is made in spite of the fact that there are not available nurses every time an employer lists a vacancy. Nevertheless, there are countless ways in which employers find Placement Service usful besides filling a vacancy. These include reliable reports concerning the applicant, as well as information regarding trends in salary, working and living conditions.

It is the real hope of the Registered Nurses Association of British Columbia that Placement Service will fill the place in the community for which it was designed. If it succeeds it will be a source of reliable information when surveys are conducted to ascertain the supply and demand for nurses, their working conditions, their salaries and their job satisfaction. There will be a higher proportion of nurses in positions for which they are suited and employers will receive applications from nurses who are best qualified to fill the vacancies. In other words, the quality of nursing service will improve, there will be more equitable distribution of nurses and nurses will be better prepared for their positions as a results of available vocation counselling.

Organization of Provincial Placement Service

Objectives:

1. To meet the need for nursing service within the province.

(a) To maintain a high quality of service through careful selection and placement of nurses.

(b) To bring into closer association and to co-ordinate the efforts of all those engaged in or concerned with the employment of nurses.

(c) To undertake studies of employment problems as they affect the community and the nursing profession.

(d) To act as a clearing house for any hospital, organization or private individual requiring nursing service and to serve on a 24-hour basis as a private duty directory.

2. To provide vocational counselling to nurses.

(a) To assist a nurse in obtaining a position and in the field of nursing best suited to her preparation and potentialities.

(b) To obtain up-to-date information concerning positions and professional opportunities for nurses.

(c) To secure credentials of any nurse who desires to identify herself with Placement Service.

(d) To maintain a cumulative record of each nurse enrolled.

Organization:

1. Membership:

(a) *Placement Bureau Committee*:

(1) Chairman shall be named by the Council: (2) Chairmen of the three Provincial Sections; (3) Chairman of the Advisory Board to the Placement Service Committee; (4) A representative of each District or Chapter sponsoring a Regional Branch; (5) Ex officio members: president

of the Registered Nurses Association; registrar of the Registered Nurses Associaion; director of Placement Service; (6) The Councillors as defined in the present act.

(b) *Core Committee of the Placement Bureau Committee*:

(1) Chairman of the Provincial Placement Bureau Committee; (2) registrar; (3) president of the Registered Nurses Association; (4) director of Placement Service; (5) to be appointed by the Provincial Placement Bureau; (6) to be appointed by the Provincial Placement Bureau Committee.

(c) *Advisory Board*: (Advisory to Provincial Placement Bureau Committee)

(1) Chairman appointed by Placement Bureau Committee; (2) a representative of each District or Chapter sponsoring a Regional Branch; (3) one Doctor; (4) one representative of the Council of Social Agencies; (5) one representative of the Hospital Association; (6) registrar of Registered Nurses Association ; (7) director of Placement Bureau; (8) chairman of the Placement Bureau Committee.

2. Functions:

(a) Placement Bureau Committee:

(1) To appoint a Director of Provincial Placement Bureau Committee on the recommendation of the Registrar; (2) to recommend to the Council the organization of additional Regional Branches as the need for them becomes apparent; (3) to examine the budget set up by the Director and make recommendations to the Council before the 31st day of January each year; (4) to define policy; (5) to act in a consultant and advisory capacity to the Director of Placement Bureau; (6) to develop new functions as the need for them is demonstrated; (7) if and when it is deemed advisable, to establish categories into which persons engaged in rendering nursing service can be placed.

(b) Functions of the Core Committee:

The Core Committee shall have the authority to execute the functions of the Placement Bureau Committee between meetings of the Committee.

(c) Functions of the Advisory Board:

To act in an advisory capacity to the Placement Bureau Committee on all matters referred to the Board by the Committee.

Duties of the Director of Provincial Placement Service:

(a) to put into effect the policies outlined by the Provincial Placement Bureau Committee; (b) to prepare an annual budget for presentation to the Provincial Placement Bureau Committee; (c) to supervise the organized Regional Branches; (d) to recommend and to assist in the development of additional Regional Branches as the need for them is indicated; (e) to assist in the development of such Directory Service as may be indicated in those areas which have no Regional Branches; (f) to collaborate with the Registrar in the implementation of studies; (g) to maintain an efficient record system, such as, statistical information, accumulative records for all nurses enrolled; (h) to inform the public, the medical and nursing professions of the objectives and functions of the Service as authorized by the Committee; (i) to co-operate with those organizations and individuals who have a responsibility for and an interest in providing an adequate and efficient service to meet the health needs of the community.

Duties of the Director of a Regional Branch:

(a) To put into effect policies of the placement of private duty nurses as outlined by the Provincial Placement Bureau Committee; (b) to collaborate with the Director of Placement Service in the implementation of studies affecting private duty nursing.

Termination of the Waiver Clause

The Registered Nurses Association of British Columbia gives notice that nurses who graduated from approved schools of nursing prior to April 22, 1921, and who did not obtain a certificate of registration, may make application for registration without examination up to but not after *April 20, 1947*. The termination of this privilege is provided for in Clause XV of the Registered Nurses Act, assented to March 15, 1944:

"For a period of three years after the coming into force of this Act, upon application and payment of the registration fee by such person, the Council at its discretion may admit to membership without examination any person, otherwise qualified, who graduated from a school of nursing before the twenty-second day of April, 1921".

Any nurse in the above mentioned category who wishes to make application may obtain the necessary form from Miss Alice L. Wright, Registrar, Registered Nurses Association of British Columbia, 1014 Vancouver Block, Vancouver, B. C.

GENERAL NURSING

Contributed by the General Nursing Section of the Canadian Nurses Association

Rambling Thoughts by a Nurse Returned from Overseas

I. Britton

Life in England was indeed pleasant for the group of ninety nurses in the field unit to which I was attached. Bicycle rides along the beautifully quiet and scenic English country lanes occupied many off-duty hours.

Places of historical interest were particularly fascinating as, for instance, old Clarendon Palace where lived many notables, amongst them the instigators of the Reformation. Do you want to see it? Then just thread your way up a long hill by a narrow bicycle path, go through some trees and there you see the stone doorway with its inscription, added in later years. You can climb over parts of the huge fireplace and make out the figure of a dragon worked out on the bricks in lighter colored clay. On the way back let's stop along the bank of the river Avon. (England has many rivers called Avon). We will remove our shoes and ankle socks and go paddling. It's April and the water is cold but the sun will soon warm our feet again.

Tomorrow afternoon there is an invitation to tea. We are free at four o'clock; you see we work a straight 8-hour shift. The tea is with the Chamleys' who live on a farm six miles away. Peddling along we meet a tractor pulling a three-bottom plow just as we are passing a quaint thatched-roof cottage, literally smothered with roses and honeysuckle. Our friends on the farm tell us all about what they are doing. We find that Mr. Chamley formerly taught at the Royal Agricultural College and now supervises this thousand-acre farm and has students there for practical experience. There is a huge, rambling stone house with three staircases and I don't know how many rooms. What fun we have! And for tea — soft cooked eggs — perfect! We haven't seen an egg since we were last on a farm for tea! We ride back in the moonlight hours and tonight it's foggy. Better turn on the bicycle light. Of course the glass is blackened somewhat so there is only a glimmer of light. It does not help much to see the road but prevents anyone bumping into you. Whoops! there I've done it. Must have got my front wheel too close to that bank at the side of the road. Turned me for a "flop" in nothing flat. Yes, I'm alright but I took the knee out of this slack suit. You can laugh, guess I did look funny. But let's get moving or it will be pitch dark before we get 'home'. Did we just get up from tea? Here is supper ready and is it good! After all we've ridden six miles!

Sunday evening — quiet and still. We can put on one of the few silk dresses we possess with high-heeled slip-

pers and gather in the Recreation Hut for our Sunday evening concert. It seems to be Bach this time — recordings you know — and Tchaikowsky's Fifth. Our old dog Toby loves to come in and lie on the rug. He is content if there is good music but just let a radio blare forth with swing 'stuff' and Toby is up, shaking his head, and is out the door in a minute.

Experiences varied all the way from group singing in the small homes of working people to a tea in London, given by the Royal College of Nursing for nurses from overseas, which was attended by Queen Elizabeth. As she passed from the hall she shook hands with each of us and asked, in her gracious manner, about our trip over and whether or not we liked England.

The hospital we staffed was essentially for military personnel but we took civilians as well. Old people were there and babies too. As when one of the hospital nurseries in our little city had an epidemic of diarrhea, they transferred a number of babies to us. One of our doctors is a well-known pediatrician at home.

The English are reserved and sometimes distant. But if one approaches them with courtesy and respect for their ways and traditions, you are taken into their hearts and homes and you have as true friends as you've known anywhere. Twenty-six happy months in England left me with a deep and abiding faith in a great and noble people.

Blue Cross to the Nurse's Assistance

In a recent editorial in *The Canadian Nurse* a comment was made that nurses do not take good care of themselves. This is particularly true these days when there are so many demands upon their services. While some nurses receive hospitalization when associated with a hospital or through a special arrangement in their alumnae, many do not have this protection as a part of their working arrangements. Moreover, few private duty nurses are protected against the hazard of unexpected hospital care particularly when they are not in the city where alumnae benefits might be available.

The solution to this vital problem is to be found in the Blue Cross Hospital Service Plans, of which there are eighty operating throughout Canada and the United States, protecting sixteen million persons against the cost of hospitalization whether through illness or accident. Benefits, costs and requirements of these plans vary slightly from province to province and for accurate information regarding the plan in your own community it would be well to make local enquiry.

The Quebec Hospital Service Association benefits are available to all employed registered nurses in Quebec, either through their alumnae, hospital groups, or nursing registries. The applicants must be under sixty-five to be accepted but have the privilege of continuing to subscribe thereafter up to seventy years of age. To date this Association has given protection to many such groups. Our experience is that nurses are anxious to avail themselves of this coverage. They have come into contact with many individuals and families who have delayed hospital care for fear of the costs involved and, at a later date, have to be hospitalized when an acute condition arises, resulting possibly in a longer hospital stay and additional expense. No matter what our social status may be, hospitalization is always a costly business. In most cases, the expenses present a bigger worry than the actual illness itself. People are often paying their bills long after being discharged from hospital or else they are forced to spend a very tidy nest-egg or bonds which they may have counted on for their old age or time of unemployment. Blue Cross counteracts all this. By paying a small sum monthly or annually, to a common fund, the heavy expense is shared among many.

These plans are operated for the benefit of all. One of their main purposes is to raise the health standard of the community and consequently should appeal very strongly to all nurses.

—AILEEN G. VERRAN

The M.G.H. Sports Program

KATHLEEN CLIFFORD

It has long been thought that an active sports program should be integrated into the curriculum of the nursing school. It is most beneficial to the students' moral, physical and mental well-being. Due to problems, which one never finds in other types of schools, it had been felt that there were too many difficulties. These problems which high school and college sports directors do not have to contend with concern rigid hours of duty, classes in off-duty hours, night duty and affiliations. They constitute a major item to be considered when attempting to organize inter-class teams, tournaments and the like.

In September 1944, after a very active tennis season, we held a meeting of the Montreal General Hospital students and discussed plans for organizing a more extensive program for the winter. The enthusiasm of the students was so great that it was decided to try to arrange definite activities. We were assured of every one's co-operation as we knew it should be part of the facilities available to the student in school. We had many suggestions as to what sports should be included and finally settled on five of the most popular — mainly, basketball, swimming, badminton, ice hockey, and tennis. An executive was formed with a chairman, secretary, a sport representative from each class, and a captain or manager for each sport, giving us a total of thirteen on the committee.

We then had to see what facilities we had for these varied activities. Our own gymnasium was too small for organized games excepting badminton. Fortunately, we were able to obtain the use of a gym floor in a nearby school once a week for basketball; membership tickets were

A tense moment in the basketball game.

bought for the Knights of Columbus pool enabling the students to swim there three nights a week. The engineering department fixed up our rink on the tennis court with boards, lights, and goal posts for hockey.

The executive met and a schedule was planned. The problems in the arrangement of our program were many and very ticklish. How were we to get the students down from the affiliating schools? How could we keep teams together with the varied rotations, night duty, etc., considering the fact that all of these activities had to be arranged for the evening? Since we have an average of fifty girls on affiliation at any one time it was decided to make one person at each of the affiliating schools our contact, and notices of games and events were sent to her to be posted on the bulletin boards so that all our students could be aware of what was taking place. Nurses on night duty often asked for their night off so as to take part in the monthly swim meets or the big basketball game. Needless to say the personnel of each class team was never the same for two successive games which after all was perfectly alright and what we wanted, as the main reason for the whole plan was to give as many people as possible exercise, not just winning each game. I must add there were a lot of questions asked by the class sport representative as to the whereabouts of her best player if she were not present—only to find she had started her night duty period.

An outline of the various activities undertaken, prepared by the sports captains, follows:

Badminton:

The gymnasium is open every night and so far there has been a fair turn-out. The hospital has supplied badminton rackets and birds, for those who have not their own. To make the sport more interesting a tournament has been drawn up. The graduates on the staff and the dietitians of the hospital are also taking part in this tournament. Competition is very keen. Inter-class tournaments are also on the program, and we do hope to challenge outside hospitals and maybe some of the city clubs. (*Hilda Motherwell*).

Tennis:

Twenty-six girls took part in the first tournament of women's singles, and the courts were filled with revived night nurses in the fresh mornings, and the energetic day staff in the evenings. The champion was presented with a racket of her own choosing by the president of the hospital, Mr. Ogilvy. We joined in a friendly game with the Homoeopathic Hospital during midsummer, and enjoyed ourselves immensely. Our annual tournament with the Royal Victoria Hospital nurses came at the end of the season, and although it was rather cold a lot of fun was enjoyed by all. We are looking forward to an equally successful time in this sport next year. (*D. Conroy*).

Hockey:

At first the suggestion of a hockey team met with much scepticism but now plans are being made with true Canadian zest. Our goal nets and posts are being provided from the hospital workshop. Players supply hockey sticks and other minor equipment. We have enough players enrolled to form four or five inter-class teams. Nurses wanting to play range from figure skaters to volunteers for the position of goalie. There are also a good number of students who have played before. Our schedule consists of inter-class games inter-hospital games and, if we prove to be good enough, we hope to challenge the housemen of the hospital. (*M. Findlay*).

Basketball:

We were able to secure the gymnasium one night a week at a school situated quite close to the hospital. There we found a well-lighted and well-equipped play room with a courteous and friendly janitor in attendance. An average of twenty-five nurses were present each night and seven teams were organized. The program for the first session closed in December, the winning team to receive a trophy. After Christmas it is proposed to form a hospital team so that inter-hospital matches can be arranged.

(*E. Lisson*)

Swimming:

The inclusion of swimming in the sports calendar was made possible when sixty inter-changeable memberships were obtained at the Knights of Columbus pool for three

nights of every week. Willing instructors do much to encourage the beginner and help the more professional swimmer or diver to perform her art more gracefully. Much unknown talent is being revealed. Monthly meets are held and courses leading to the Bronze medal in life saving are top hits.

(*Romayne Royston*)

We were very fortunate in attaining our goal so easily. When we first tackled the task of organizing, the case seemed hopeless but with perseverence and patience, the excellent help and wise advice of the principal of our school, many of our headaches were eliminated.

In conclusion may I add that in every activity the enthusiasm runs high. We are so pleased to see the students coming out for the relaxation afforded them by the exercise and the rivalry between the different classes causes non-players to turn out to root for their own class-team. We have many plans which we hope to carry out this winter, such as a sleigh drive, ice carnival, ski-party, and fancy swimming exhibition. We hope to have a banquet sometime in May to finish off the season to present the prizes won by the classes and individuals.

One must always remember that the education of the student comes first and that the athletic program is, at present, but an extra-curricular activity, but I do hope that in the near future it will be integrated into the school curriculum and be a *must* for every student in the school.

The Gambiae Mosquito Comes Back

In former issues of the Rockefeller Foundation Review an account has been given of the successful campaign in Brazil against the dangerous malaria-carrying *Anopheles gambiae* mosquito whose home is in Africa. After high death rates and enormous suffering, and with great labour and cost, it can be said with confidence that the gambiae species was eliminated from Brazil.

The Foundation was therefore disturbed to receive, during 1943, advices from its representatives in Rio de Janeiro that gambiae mosquitoes, some of them alive, had been found on planes coming from Accra and Dakar in Africa to Natal. Even more disturbing was the news that five live gambiae had been discovered in dwellings near the Natal airport. Incoming planes from Africa are, of course, fumigated both before they leave Africa and before they land in Brazil, but a few mosquitoes were evidently able to stow away safely in the modern, complicated airplanes. When it is realized that a single fertilized gambiae could start a conflagration similar to that which swept north from Natal in the thirties, the danger of the situation becomes apparent.

Thanks to the efforts of the Brazilian and United States authorities, the immediate situation is now in hand. But it poses a problem of larger significance which cannot be evaded. Around the ports of Africa and deep within the hinterland lie the breeding centers of the gambiae. The safety of the Western Hemisphere, which is now within a few hours' flight across a narrow ocean, can no longer be left to the uncertainties of a flit-gun campaign. Modern airplane travel has made old methods and ideas of quarantine completely obsolete. If the Americas are adequately to be protected, the breeding places of gambiae, wherever in Africa or elsewhere they may be found, must be eradicated. The cam-

paign must be carried to the sources of infestation. It can no longer be defensive; it must be offensive.

But the problem, of course, is far broader than gambiae. This newly made world which the airplane has tied together has lost its frontiers. Certainly in the field of public health they no longer have significance or meaning. No line can be established anywhere in the world which confines the interest of any one country, because no line can prevent the remote from becoming the immediate danger. Whether it is malaria or yellow fever or typhus or bubonic plague or whatever the disease may be, the nations of the world face these enemies of mankind not as isolated groups behind boundary lines but as members of the human race living suddenly in a frightening propinquity.

Public health can no longer be thought of exclusively in national terms. Whether we like it or not, our technologies now confront us with inescapable demands for a new approach. Some kind of regularized international cooperation is essential. Whatever we may think of the League of Nations, its Health Organization blazed a new trail in the international attack on disease — a trail that must be widened into a firm road. Certainly a service of epidemiological intelligence covering the whole world is an immediate necessity, and many other essential public health activities not only lend themselves to collective approach but can be effectively handled only by that method.

In relation to great scourges like malaria and influenza — as indeed in relation to many other perils — nations today are roped like Alpine climbers crossing a glacier: they survive or perish together.

In 1925, after an extensive survey by a commission sent out by The Rockefeller Foundation, a laboratory was built in Lagos, West Africa, for the study of the epidemiology of yellow fever and its relationship to the yellow fever of South America. It was in this laboratory that many of the tangled threads of the story were unraveled. It was here, too, that tragedy struck, in the death, through yellow fever, of four brilliant scientists, Dr. Adrian Stokes, Dr. Hideyo Noguchi, Dr. William Alexander Young and Dr. Theodore B. Hayne. They gave their lives — as others did in the Americas — in an attempt to discover the secrets of this dread disease. As we look back on the progress that has been made in twenty years in increasing our knowledge of yellow fever and arming us with tools to control it, we can truly say these men did not die in vain.

When these pioneers started work in Lagos, no protective vaccine had been developed, no laboratory animal susceptible to the disease was known, no viscerotomy method for diagnosis had been devised, no blood tests to determine immunity had been evolved. Moreover, the whole epidemiological concept of the disease, particularly the idea that the *Aedes aegypti* mosquito was its only carrier, was based on foundations which experience and experiment were to prove unsubstantial.

The laboratory at Lagos was abandoned in 1934. It was felt that its work had been done and that other centers could more effectively carry on the research. Because an immunity survey had shown the previous presence of yellow fever in vast sections of the country, all the way from Nigeria eastward to the upper reaches of the Nile, a new laboratory was opened in Entebbe, in Uganda, in 1936. Since that date, this laboratory has been the center of research in yellow fever in Africa, while the New York laboratory and the South American institutes have carried the responsibility in the Western Hemisphere.

But in 1943 it was decided to reopen the Lagos laboratory. The buildings are still standing, and personnel, both American and British, has already been assigned. This laboratory will serve as a center for distributing yellow fever vac-

cine to troops and settlements in West Africa and will constitute a consultative service to the government authorities in the British colonies of Gambia, Sierra Leone, the Gold Coast and Nigeria, where yellow fever has long been endemic. Moreover, there are still puzzling questions about this disease for which answers can be found only in a laboratory.

The most striking difference between yellow fever in Africa and yellow fever in South America is that in the former continent it has not yet been possible definitely to prove the existence of the "jungle" type, since in Africa no rural area has yet been found from which the *Aedes aegypti* mosquito is absent. To be sure, suggestive evidence of the presence of jungle yellow fever has been obtained by workers in the laboratory in Entebbe, who have isolated the virus from wild-caught mosquitoes other than *aegypti*. One of the main objectives of the new program centering at Lagos is to find out whether the jungle variety discovered in South America has its counterpart in West Africa. If this proves to be the case, studies will be made there of the mechanism by which this form of yellow fever is transmitted to man, and this research will be tied in with similar research which is now going forward in South America.

The return to Lagos has a certain symbolic interest for The Rockefeller Foundation, for it was in West Africa, in 1927, that a blood specimen was taken from a black native named Asibi who was sick with yellow fever. This specimen was inoculated into a rhesus moneky which had been received from India. Asibi recovered, but the monkey died of the disease. All vaccine manufactured since 1937, both by The Rockefeller Foundation and by government and other agencies as well, derives from the original strain of virus obtained from this humble native. Carried down to the present day from one laboratory animal to another, through repeated tissue cultures and by enormous multiplication, it has afforded immunity to yellow fever to millions of people in many countries. Wherever today in yellow fever areas the armed forces of the allied nations are stationed, they are protected from the disease by vaccination from this same strain. Through the creative imagination of science, the blood of one man in West Africa has been made to serve the whole human race.

—*The Rockefeller Foundation Review*

News from Greece

(*Editor's Note*: Miss Jean E. Browne, national director of Junior Red Cross, sent us the following letter received from Captain A. L. Kerr of the R.C.A.M.C. stationed in Greece. We are sure the Old Internationals in Canada will be interested to hear that Miss Messolora is alive and well).

Whether this letter reaches you or not will be a fair test of the postal services. Before passing on the message which I have for you, I had better explain. Having come to Greece a few weeks ago with the British parachutists, to which I am attached as a Medical Officer, I was visiting the Red Cross Hospital in Athens, as part of my off duty sight-seeing. Along with some English doctors, I had gone to watch Professor Maceas, their senior surgeon, operating. Realizing that I was a Canadian Miss Messolora, who had interpreted for us, asked me to write to you. Since civilian mail services have not started yet, I asked what message she would like to have passed on to you, and promised to do my best to return any news to her that you sent in reply.

Her message reads: "To Jean Browne and the Old Internationals in Canada — happy thoughts from a free Greece after long suffering, from C. J. Messolora and the nurses of Greece — and recognition for all done for us by the Canadian people". She asked to be remembered to all her friends, not all of whom she could name.

The gratitude of the citizens here can hardly be expressed in words for the help during this war from the Canadian Red Cross. So many have told me the same story, of how they could not have kept going without that help. These are people well worth befriending, for one can see at once how much they have tried to help each other. Of our own casualties, most, at first, were nursed by Greek women, who treated them as their own, and who were broken-hearted when I evacuated them later on to a hospital. One man, who was being looked after by an aged couple, complained of a cough, and thoroughly enjoyed the old-fashioned "cupping" which was applied. I think my daily visits were looked on as an interference in their daily nursing routine! I shall try to pass on your news either directly or indirectly to Miss Messolora.

Noted in our Exchange Journals

After very careful study by the Nurses and Midwives Registration Board of New Zealand, their solution to the problem created by the large number of nurses aides has been given official sanction. Their plan provides that if these aides can satisfy the Registration Board that they have "performed not less than six thousand hours of nursing duties, during a period of not more than four years, in not more than four institutions approved by the Registration Board" they may apply to take the prescribed examination for Nursing Aides. These applicants must hold recognized certificates in home nursing, first aid and hygiene as well as evidence of having had a period of sixty hours training in a hospital such as meets the Board's requirements. Those who are successful in passing the examinations "will have the recognized status of Nursing Aide and their names will be recorded on the registrar; many positions in hospitals, other than training schools, will be available for them, and in a sphere of work in keeping with their knowledge and under the supervision of trained nurses, they will fill a useful place in the nursing world". For those more youthful applicants who may wish to qualify as registered nurses, "the nursing aide certificate will entitle them to a credit of one year of that training".

The *Nursing Journal of India* records editorially the difficulties that have to be met in securing a sufficient number of prospective student nurses. "As yet education of women in India has not advanced to the place where it is possible for us to get enough students to produce the number of nurses we need if we insist on the educational requirements held today by our better schools or even those held by our nursing councils as their requirement". Rather than accept the alternative of lowering the present standards it is suggested, as a *temporary* measure, to have two standards of nurses. "One of these groups would be the finest nurses we can make out of the finest student material India can supply . . . The second group would be drawn from the much larger group of young Indian women who finish middle school, but cannot go on with their general education . . . They will greatly extend the nursing care it is possible to provide".

The *South African Nursing Journal* carries the report of the inauguration of the Block System in two of the schools of nursing. "Under this system the students' ward work and lecture room study are entirely separated. The student nurse has no long hours of study when on ward duty, and the strain and responsibility of nursing is removed when concentrating on theoretical study".

To meet the situation created by the war demands for nurses aides who may wish to enter upon their training to become fully qualified nurses, South African nurses secured authority to grant "three months for every year of military nursing up to a total of twelve months" In other words, up to a year may be deducted.

Notes from National Office

Contributed by GERTRUDE M. HALL

General Secretary, The Canadian Nurses Association

Nurses of Great Britain Point the Way

A recent issue of the *Nursing Times* carries a leading editorial on the appointment of an Advisory Board on Nursing Education to the Council of the Royal College of Nursing. Prominent and leading educationalists from the field of general education are among the members of the Board.

The object of the Council in settling up this Board is to ensure that nursing education is recognized as education and benefits by the advances in educational methods and facilities which are characteristic of present developments. We used to speak of the training of the nurse, stressing rather the practical art than the scientific basis on which the practice should stand. The Council speaks of education and training; in fact, this was chosen as the title of one of the most important sub-committees of the Horder Committee. It is essential for the future of nursing that both during her professional education, her preparation for it and her post-certificate education, the nurse benefits by help and advice which are both educationally sound and professionally appropriate. The Board, bringing together as it does both specialists in general education and specialists in the professional field, will ensure a greater recognition of and a greater contribution to nursing education from other fields, so that those who know about nursing have the assistance of those who know about education.

Committee on Legislation

The first draft revision of the Constitution and By-Laws is underway. This will be sent to all Provincial Associations for their official consideration regarding (1) its legal relationship to each Provincial Act, and (2) its adaptability for effective functioning of professional interests.

The committee will need all the suggestions and help which the Provincial Associations can contribute if the revision is to fill the needs of both the provincial and national associations.

Committee on Labour Relations

Following a resolution submitted by one of the Provincial Associations relating to a special request to the Federal Government made by the Society of Professional Engineers who were seeking for a definition of their standing in regard to P. C. 1003, the Canadian Nurses Association sought the advice of its solicitor as to the status of nurses and were informed that no immediate action by this Association was necessary. In the meantime, however, the Engineers' Society has proceeded with the drafting of a proposed Order-in-Council which will cover the problem of collective bargaining so far as professional workers are concerned.

Legal advice was again sought by the

Canadian Nurses Association as to the advisability of preparing a brief for submission along with that of the Engineers' Society. The solicitor advised against taking any action in this regard. He did, however, recommend:

That each organization employing two or more nurses be required to have the authorization of at least 50 per cent of their nursing staff to secure authorization for their Provincial Association to act as their collective bargaining agents.

The labour relations committee feel that with the frequent turnover in nursing personnel this might lead to considerable confusion and, therefore, this matter shoud be given considerably more study by both national and provincial associations.

Donations to British Nurses Relief Fund

We gratefully acknowledge donations from the following Provincial Associations to the British Nurses Relief Fund: British Columbia, Mary Campbell, $4.00; Penticton Chapter, R.N. A.B.C., $20.00; Princeton Chapter, R.N.A.B.C., $15.00; Cowichan Chapter, R.N.A.B.C., $6.20; Vancouver General Hospital Alumnae, $600; Kamloops-Tranquille Chapter, R.N.A.B.C., $20.00; Alberni Chapter, R.N.A.B.C., $50.00; *Total* $715.20.

From the Registrar of the Registered Nurses Association of the Province of Quebec comes the following: "We are pleased to enclose herewith cheque for $1,000., being a contribution towards the British Nurses Relief Fund. Although no particular publicity was given to this fund for over a year, the money was subscribed by the same members of the Registered Nurses Association of the Province of Quebec who continue to do so regularly."

Short-Term Bursaries

Nurses are reminded that applications for short-term bursaries can be received in the provinces until March 1, 1945. They must be in National Office for the consideration of the national committee not later than March 10, 1945 and any short-term courses taken on 1944-45 bursaries must begin not later than June 1, 1945.

Data and Summary Report

The accompanying table shows distribution of student nurses for 1944 according to year-in-training, with the 1943 comparative figure in Grand Total only.

Supplementary information from a variety of sources enables us to make a further statement regarding the student recruitment returns:

1. The majority of schools of nursing have reached the maximum in housing accommodation.

2. In October, 1944, the replies from the provincial secretaries indicated that full classes of students had been enrolled in virtually all schools. The greatest difficulty in securing students is being experienced by the very small schools, while the larger schools still have a waiting list of applicants.

Social Hygiene Day

On February 7 Canada observed its second annual national Social Hygiene Day sponsored by the Health League of Canada, in co-operation with the federal and provincial departments of health. The day was set aside to re-focus attention on the Dominion's No. 1 public health problem. Through such obser-

DATA AND SUMMARY REPORT ON STUDENT NURSE ENROLMENT IN SCHOOLS OF NURSING IN CANADA AS OF NOVEMBER, 1944

Province	Probationers	1st Year	Probs. & 1st Total	2nd Year	3rd Year	Grand Total 1944	1943
P.E.I.	—	—	36	38	27	101	93
N.B.	136	172	308	158	98	564	531
Alberta	213	111	324	296	325	945	956
Ontario	1170	691	1861	1220	1292	4373	4024
Quebec							
English	174	121	295	252	292	839	
French	349	509	858	575	401	1834	
	523	630	1153	827	693	2673	2182
B.C.	231	211	442	348	342	1132	1124
N.S.	170	142	312	201	224	737	712
Sask.	208	126	334	286	258	878	848
Man.	195	106	301	281	269	851	889
TOTALS	2846	2189	5071	3655	3528	12,254	11,359

vance it is hoped to reinforce public interest in the never-ceasing fight waged by various governmental agencies — federal and provincial — and voluntary agencies led by the Health League.

Canadians were asked to take their place in the four-sector fight against VD —the four sectors being health, welfare, legal and moral. It was stressed that the outcome of the battle against these insidious diseases is of vital importance to the Dominion's war effort and the welfare of post-war Canada. Venereal diseases bring devastating results — dependency, stillbirths, sterility, blindness, invalidism, mental deficiency and mental diseases, the breaking up of homes, divorce — and death.

The nurses of Canada are reminded once again of the resolution which was passed unanimously at the biennial convention of the Canadian Nurses Association last summer:

Whereas the stresses and strains of war have aggravated the already serious situation in regard to the control of venereal diseases in Canada, and whereas the recognized leaders in this field have made preparations for a national campaign of education and extension of diagnostic and treatment services in order to rid this country of the venereal diseases, and whereas registered nurses in all fields of service can and should play an important part in this work of vital importance to the health and happiness of the people of Canada; therefore be it resolved: that the Canadian Nurses Association pledge itself to do anything within its power to promote the forthcoming campaign.

Preview

Clinical instruction has become an exceedingly important part of the teaching program in our schools of nursing. Mary Eichel has outlined the application of the principles of clinical instruction to the training received in the operating theatre.

Interesting People

After sixteen months as assistant executive secretary in the National Office, Canadian Nurses Association, **Florence Harriet Walker** has accepted the position of associate secretary of the Registered Nurses Association of Ontario. She entered upon her new duties in the middle of January.

A native of Ontario, Miss Walker received her preliminary education there and graduated from the School of Nursing of the Hamilton General Hospital. A prize awarded by the Board of Governors enabled her to take post-graduate study in teaching and supervision at the School for Graduate Nurses, McGill University. She returned to her home school as instructor for three years then moved out to British Columbia, serving in various capacities on the staff of the Vancouver General Hospital. During her stay in Vancouver, she undertook further study at the University of British Columbia leading to the degrees of B.A. and B.A.Sc. (nursing).

Hubert Beckett

FLORENCE H. WALKER

Throughout her months at National Office, Miss Walker carried much of the responsibility for the administration and distribution of the funds from the Federal Government Grants. Her sound knowledge of Association affairs and her general interest in all that concerns nursing will make her a valuable asset to the Ontario Association. She is an indefatigable worker, conscientious and painstaking, yet keenly interested in the world of music and of literature. Miss Walker's headquarters will be in Toronto.

Through the kind co-operation of the Winnipeg Board, **Adella McKee** is being released from her position as district superintendent of the Winnipeg Branch and will be attached to the staff of the National Office of the Victorian Order of Nurses for Canada for a temporary period.

A graduate of the Brantford General Hospital and of the course in public health nursing, University of British Columbia, Miss McKee first served with the Victorian Order as a staff nurse on the Calgary Branch, then for a year was in charge of the branch in Saskatoon. Following this, Miss McKee returned to Calgary where she supervised the service for three years. Eight years ago she was appointed to the Winnipeg Branch as district superintendent, which position she has filled successfully.

Miss McKee has an engaging personality and genuine interest in people. She has made many friends not only for herself but also for the organization she serves. During Miss McKee's absence, the nursing service in Winnipeg will be in charge of her assistant, **Lynette Gunn**, and we have every confidence the work will be well carried on under her direction.

Christine Elizabeth Charter has recently been appointed assistant district superintendent of the Vancouver branch of the Victorian Order of Nurses after

serving in various capacities with the Order in Halifax and Liverpool, N.S. and in Toronto.

Miss Charter who claims to be English "with a bit of Scotch", received her academic education in England and New Brunswick. She graduated from the School of Nursing of the Saint John General Hospital. After taking a postgraduate course in obstetrics at the Royal Victoria Hospital, Montreal, she received her diploma in public health nursing at the School of Nursing, Toronto University.

For recreation, Miss Charter enjoys reading and music. She is very much interested in handicrafts also.

Hudson's Bay Co., Vancouver

CHRISTINE E. CHARTER

Josephine De Brincat, who is serving as a public health supervisor with UNRRA, has served with the Manitoba provincial health department since her graduation from the Winnipeg General Hospital in 1925. In 1942, she took a special course in industrial nursing at the School of Nursing, University of Toronto, following which she returned to Manitoba as consultant in industrial hygiene. Miss De Brincat was born on the historic isle of Malta and is an accomplished linguist in both French and Italian.

Agnes D. Carson was honoured in a presentation at the Saint John Tuberculosis Hospital in November when she observed the fiftieth anniversary of her graduation. Born in St. Andrews, N.B., of Loyalist descent, Miss Carson entered the training school of the General Public Hospital in Saint John in 1892. In 1895, she went on duty as the first district nurse of the city of Saint John at a salary of $175 a year! After a brief period, she went to the New York Polyclinic Medical School and Hospital where she was superintendent of nurses until 1913. In that year she moved to Detroit to organize and superintend the Home Nursing Association.

After nine years in Detroit, Miss Carson returned to Canada and for seven years was in executive positions in hospitals in Halifax. Her professional work was interrupted for two years by home responsibilities, after which she joined the night nursing staff of the Saint John Tuberculosis Hospital where she is still on duty. Miss Carson is highly esteemed and greatly beloved by both her associates on the staff and the patients.

Miss Carson has always maintained an active interest in the work of the nursing organizations. She has served as president of the Halifax Branch of the R.N.A.N.S. and also of the Saint John Branch of the N.B.A.R.N.

A Tribute to a Gentle Lady

When the news of the sudden death of Miss Nora Tedford reaches the four corners of the earth, there will be doctors and nurses in each of them who will experience a feeling of personal loss for this gentle little lady was known and greatly loved by many in all lands.

As a member of the 1895 class of nurses of the school established by Miss Livingston in The Montreal General Hospital, Miss Tedford demonstrated marked talent and ability and was the first qualified graduate nurse appointed "in charge" of the surgical operating rooms, a position she held with great

Rice, Montreal

NORA TEDFORD

dignity for twenty-two years, during which time hundreds of student nurses learned of the mysteries of surgical technique and service from one who was a past master of the art, and of teaching method.

To those of us who learned to know of her hobbies and interests, Miss Tedford became a true and valued friend. Aside from the work of her choice, Miss Tedford found time to contribute to several pioneer nursing projects, chief among which was the establishment of the Mutual Benefit Association of her alma mater, which owes its inspiration to her alert brain and untiring efforts and regarding which she carried with marked efficiency the office of secretary-treasurer for its first five years.

Recorded in the history of the Canadian Nurses Association on page 13 is the following:

"Miss Nora Tedford of Montreal has left on record a graphic account of the proceedings of the Congress of the International Council of Nurses held at the Church House, Westminster, London, England, July 19-24, 1909."

The graphic account referred to follows and provides enjoyable reading. Miss Tedford was always proud of the fact that she had been included among the five official delegates who represented Canadian nurses on such an auspicious occasion when the Canadian Nurses Association, known at that time as "The Canadian National Association of Trained Nurses", was received into membership in the International Council of Nurses and that she carried the responsibilities of official secretary.

Miss Tedford appreciated and loved good music, one of her greatest joys in life being the love of her talented brother "Jack" (J. Leslie) who was for years Montreal's leading tenor. To watch her during the expert rendering of the Tannhauser Overture was a thrilling experience.

During the old surgical operating room days it was equally inspiring perhaps, to see her lay down her tools at the close of a big day in the theatres when she would then perch her tiny self on a high stool and execute the most fascinating needle-work. She loved the birds and flowers and knew more about botany than many an acknowledged teacher of that fascinating subject.

Miss Tedford was a charter member of the Alumnae Association of her school, for the organization of which she was to a great extent responsible, and in recognition of her services towards it the Alumnae bestowed upon her an honourary life membership of the Mutual Benefit Association.

Following her retirement from active duty several years ago, Miss Tedford decided to thoroughly enjoy freedom from responsibility, and she slipped away suddenly on January 5 at the age of seventy-five years.

—E. FRANCES UPTON.

Obituaries

Sister St. Viateur died recently at the Motherhouse of the Grey Nuns of the Cross in Ottawa. A member of the Class of 1907 of the Ottawa General Hospital, she served continuously in various departments of the hospital until ill health forced her to relinquish her duties four years ago.

Mrs. George Reid (Beatrice MacLeod) died recently in Pittsburg, Pa. Mrs. Reid was a graduate of the Prince Edward Island Hospital and a member of the Class of 1931.

STUDENT NURSES PAGE

Occupational Therapy for the Mentally Ill

ALICE L. ROSSE

Student Nurse

School of Nursing, Ontario Hospital, Hamilton.

The importance of scientifically planned and directed occupations for those suffering from various types of psychoses and neuroses, as well as for the patient whose disabilities are physical, is becoming increasingly apparent. The role of the trained occupational therapist is familiar to all who work with mental patients. However, it is questionable whether the nurse, graduate or student, realizes fully her own responsibilities and opportunities for service in this field.

Most of us who receive our training in mental hospitals are given a course in the theory and practice of occupational therapy, an interesting and fascinating study. In the press of other duties perhaps we do not apply these teachings as we might. To-day, due to the demands of the armed forces, the number of occupational therapists available for hospital work is limited. It is, therefore, a challenge to the nursing staffs to see that their patients do not lack the benefits of this form of therapy.

The nurse sees her patient for much longer periods and is in closer contact with her than is the therapist. She is in a position to suggest and supervise activities and occupations and can see how the patient reacts to these. Trained to be observant and to report her observations promptly and accurately, she can be of great assistance to the medical staff in the plan of treatment, as even a simple task, satisfactorily accomplished, is of importance. Such details as a properly made bed, or a well-swept room may be the first steps forward for a disordered mind. The supervision of the patient and her training in habits of neatness, cleanliness and self-reliance are a vital part of the mental nurses' duties; however it should not be forgotten that helping with her sewing, knitting, etc. is a no less essential aspect of her work.

Naturally a complete knowledge of the use of colours and fabrics, the teaching of basket work and the mastery of the hand loom, which are all in the trained occupational therapists' field, are far too ambitious and time-consuming for any busy nurse. Frequently, however, the therapist can be on each ward for only a short period every day, or she may visit them but once or twice a week. In the interim, the nurse who can turn the heel of a sock, decipher a crochet pattern, or assist with embroidery stitches, is indeed extending her ministrations to the fullest. The convalescent mental patient may easily lose interest and slip back if unable to proceed with a piece of handiwork, because she got into difficulties with it. Encouragement and kindly skilled help are much appreciated and fully repay the nurse for the

extra time and patience she may expend.

It must be remembered that in some occupations, for instance sewing, or the making of scrap books, there are certain hazards. A nurse with many duties cannot always take the responsibility of giving out scissors, etc. There are, however, many things, which, if one is intelligent and enterprising may be safely utilized as occupations. The use of plastic knitting needles entails little risk and the making of belts and other novelties of torn and folded strips of coloured scrap paper can be interesting when well directed. Even the provision and supervision of indoor games is beneficial.

Knowing that by increasing her interest in and applying her knowledge of occupational therapy she may further the recovery of her patients, the nurse in mental hospitals should be stimulated to greater efforts in this sphere.

We had a Campaign!!!

NATALIE HARDING

Student Nurse

School of Nursing, Homoeopathic Hospital, Montreal

A campaign is defined in the dictionary as, "the period during which an army carries on active operations in the field". This is exactly what happened at the Homoeopathic Hospital in Montreal recently. The army was our student nurses and the result of the active operations was an exceptionally high percentage of subscriptions to *The Canadian Nurse Journal* by the student nurses.

Model use in the exhibit.

A list was posted with the names of the students arranged in classes. As each nurse subscribed to the magazine, she was awarded a star beside her name. The subscriptions poured in as enthusiasm mounted and the competition began. The campaign came to a thrilling climax when the editor gave the students an extremely interesting talk on her work with the *Journal*, at the regular monthly meeting of the Student Association.

The nurses then gave a very original skit. The scenery was composed of a huge book designed to represent the *Journal*. Large wooden frames were covered with white sheeting and arranged as leaves of a book. The outer page was illustrated by a replica of that familiar blue and white cover, and the other pages were marked with huge black letters presenting the different sections of the *Journal*. A student nurse gave the introduction to the skit, and as she opened the book and turned the pages, out stepped other students who

read articles which they themselves had prepared on the various sections of the *Journal* they represented.

Was our tour of operations successful? Why, the very fact that the students not only subscribed whole-heartedly to the *Journal* but that they realized what valuable and most interesting knowledge *The Canadian Nurse* offers, was proof of its profitableness.

Here's a challenge now, you other armies of student nurses! Why not try out a campaign to raise your subscription level to 100 per cent?

Letters from the Alaska Highway District

August 10, 1944. There is nothing small in the Yukon Valley — day after day down stream, towering mountains, big islands, etc. I left Whitehorse on July 26 and reached Dawson after two nights and two days — spent five days in and around town, visited the Indian village of Moosehide, the hospital and hostel. Coming back up-stream is slower. The Yukon waters are very swift, and I travelled on a smaller boat to Selkirk arriving on Saturday. All the Indians were out-of-town for the weekend fishing, so after morning service on Sunday we all went in a small motor boat to the mouth of the Pelly river, and to a damned-up pool where the sunshine warmed the water. There we revelled in what a little girl called a hot spring — we did not think it 'so hot' and it was also muddy. We drank copious quantities of coffee and had a couple of soup-bowls apiece of ice cream, which the men made upon arrival on the island.

Monday morning the R.C.M. policeman and I set off up-stream in a small motor boat for Minto, where a band of Indians were gathered. The twenty mile trip in the open boat took almost four hours, and one sees the beauty of the islands more intimately at close range. After gathering the Indians at the old roadhouse, built to accommodate the '98'ers, the policeman listed the people and prepared their arms while I vaccinated them and gave the first of two doses of alum precipitate toxoid for diphtheria. This, of course, needs only two doses, and I go back again in six weeks. An old man who has lived at Minto since the days of '98 (and keeps a dirtier house than most of the natives) prepared a meal for us. He boiled potatoes, grown in his own garden, and opened a can of Prem, and we *had* to eat.

The following day we travelled up the Pelly river about fifteen miles. Here we had no building in which to work. A wooden box was brought out and covered with paper towelling. I placed my sterile cover with syringes, etc. on it, with an alcohol lamp sheltered by a bottle of pills in one corner. Above our heads stretched a piece of canvas sheltering some poles on which hung whole filleted salmon at one end and the complete vertebrae and tails tied in bundles at the other. In the centre was the usual fire of smoke to keep away the flies; this was a great help, only just as we commenced operations the wind changed and we were in the line of fire, or rather smoke. The children ran away and we thought they had gone to hide, so were amazed when they returned and stood before us with hands and faces washed and clean print dresses on. On the third day we worked on the natives, who had by this time returned to Selkirk. Here we had a clean school-room and did everything in the orthodox manner. Quite a number of white people were vaccinated here.

The trip up-stream has been of intense interest, so much to see when we travel at slower speed. Five Finger Rapids, "Cape Horn" (a very dangerous corner to navigate), and so much more I could tell you about, but it would need to be seen to be appreciated—mountains, valleys, creeks, streams, rocks, basalt, volcanic ash, sand, wood-camps, and fishing stations.

Yesterday afternoon we stopped at a large wood-camp at my request. The local Anglican missionary came ashore to help me and two volunteers from among the passengers. We went into the wood-cutters' cabin — fairly clean and tidy (one room with every-

thing in it). We started a wood fire to provide boiling water for the needles. On the kitchen table we spread our supplies and gave the first dose of toxoid and vaccinated all the natives. The help was all 'green' but very willing. The state of these people is pitiable in the extreme; so much needs to be done for them and it is going to take a lot of careful planning for their future health. There are so many bands, so widely scattered and they vary so in intelligence and in cleanliness or filth.

August 20, 1944. Am writing you from Ross River — it is east from Selkirk on the Yukon river and north from Johnson's Crossing. To reach it I came along the Highway to Johnson's Crossing and north from there 141 miles. It was a hurried preparation, my medical supplies were ready, but clothes had to be left till the last minute as they crease so in a gunny sack. We travelled sometimes at fifty miles an hour, sometimes at five and averaged thirty-three. The countryside is something like the White Mountains or Adirondacks. (Interruption — an American Army youngster came to my tent with a couple of bars of chocolate for a chat; poor kid, from the Bronx, New York City, wanted to know if I wasn't lonely in this awful country. I told him to gather some wood and bring some of the other boys, and we would have a bon fire by the water and a sing-song at 8 p.m. They have nothing to do to keep out of mischief in an Indian village).

To go back to my story, we arrived at the ferry at the Pelly river where the Ross river empties into it and found the ferry on the other side and no one around. There was a wooden foot bridge with steel cable suspension supports, and my driver walked across while I sat and drank in the scenery. It was different; the river valley is broad, with tall spreading willows, good soil, and the very high hills covered with pale green, grassy moss; the soil erosion of centuries makes queer formation along the Pelly. Across from the flats on which the trading-post and village are built there is a very high plateau, which looks to me like lava from a volcanic eruption; there are evidences at other places but this is quite different from anything I have seen anywhere. The whole scene, viewed from the other side where I sat, looked like a tremendous, futuristic painting in pastel shades.

We reached camp in time to meet the men coming out from supper, but there was still cod with shrimp sauce, potatoes, beans, coffee, and pie left. I am used to eating in these camps now, wooden benches with tables attached as at picnic grounds, everything on the table, and all help themselves, cup and plate, knife, fork and two spoons. They found an extra plate for my pie. We stopped at the store for the key to a supposedly unused log cabin only to find that someone had moved in a month before. There were members of a geological survey in one cabin, and my prospective abode was occupied by their truck driver and his *wife and baby*. She certainly was glad to see me. Her husband was away till the following day, so two of the men came over with a cot, mattress and sleeping bag, and I was settled for that night. The next morning I walked over half a mile back to the camp for coffee and toast, gathered the Indians into the trading store where I vaccinated them all and put on the Vollmer patch for the tuberculin test. The people are friendly and respectful and welcome the nurse. Down to the trading post this morning and gathered the people to remove patches and found twelve more waiting for me — they had hidden on Saturday and now wanted vaccination and patch.

On Saturday evening some of the geologists had put up a tent for me and I have my cot, sleeping bag, a table, and all my kit in it. The sun is beating down fiercely just now and I am *warm*, but the nights are frosty and good for sleeping (the tent is covered with frost every morning and my clothes are wet and have to be hung to dry before I can dress). Last night a wolf howled near by and set all the dogs barking and howling, and I had visions of a wolf's nose poking under the tent flap! I am at the far end of the village and few can see me.

Tuesday afternoon the sun was scorching hot as it had been on Monday. Mrs. X and I went for a walk to the Indian cemetery. I had invited three young Indian girls, all newly married, to come with us. As we walked I pointed out edible weeds and explained how to prepare them, also how to prepare rose-hips for jam and jelly and how to make a syrup rich in Vitamin C to take the place of oranges. We found a tidy, well-kept cemetery with so many graves marking the resting-place of young children. There has been no one to teach them how to cook or what to eat but they are so willing to learn.

—Minnie Hackett.

The Nurse – a Welcome Sight

"One thing I know" — reports Mrs. Frances Payne Bolton in the January 1945 issue of the *American Journal of Nursing*, after a two months' visit to hospitals of England and areas of France which have been liberated — "Were I fit and young enough and *trained* nothing would keep me from meeting the greatest challenge American life has ever given women who are nurses. If I were trained in nursing or physical therapy or as a nurse's aide and unable to go overseas I would apply for service in our hospitals here to which these men of ours are coming by the thousand. I wouldn't miss the experience altogether. I wouldn't go into it just because of the terrible need our wounded have for care: I would do it partly because I know I couldn't face myself in the years that inevitably come, when one looks back on life, if I had let the opportunity to live deeply pass me by.

Recalling her experiences, Mrs. Bolton writes:

"On D-Day plus four the first of our women joined our men on the shores of France for the healing of nations — even as they had joined them in Africa and Sicily and Italy — even as they are with them in India, in China, or the islands of the Pacific and in the unbelievable hospital ships of the air. No wonder a soldier's eye lights up when he speaks of a nurse, no wonder!

First to a well-housed general hospital! Brick buildings that originally held an English hospital with additional Nissen huts to bring it up to the necessary number of beds. The best possible equipment and general facilities, an exceedingly efficient, an exceedingly understanding C.O. and a splendid staff. True, the staff was small, considering the number of beds: something between 1,000 and 1,500 beds, and 50 doctors, 83 nurses, 200 enlisted men; but the difficulty in securing both doctors and nurses forced a general reduction from the original numbers.

Nursing on these particular wards was heavy. Men who cannot move themselves need to be turned and rubbed and turned again every two hours in addition to the regular care their wounds require. Yes, heavy nursing but infinitely satisfying. On other wards were men with bandaged eyes unused to darkness, faced with grim certainty that the only sun that they will ever see must rise in their own hearts; men without legs, without an arm, with terrible body wounds, men with shattered faces, their jaws wired together, sucking their food through tubes. Most tragic of all are the men with broken nerves and shattered minds, lost in the chaos of a destruction they could not withstand. On still other wards were men terribly burned, yet not beyond hope, for the wonderful easement of the hours in the saline tubs relaxes their tensions and brings healing. They are upheld by the promise that when nature has done her temporary best, plastic surgery combined with an infinite patience will rebuild a leg, a hand, an arm, a face so that living a normal and constructive life will become first a possibility, then a certainty.

I shall always remember two lads, one with his right arm in plaster hitching along with one knee on a chair, his foot bandaged, the other with his left hand in splints, the fingers on traction. Together they had a pair of good arms with which they were shaving the ward!

I talked with a soldier one afternoon who was to go home. Lo and behold! At the airstrip a few days later there he was on his litter, his x-rays under his pillow, his little bag of valuables tied on, his eyes shining. A doctor went on that particular plane: there were some pretty sick men aboard that needed to get home. Usually the nurse carries the responsibility alone. Ask the men sometime what they think of those flight nurses!

In France it was all very different, yet curiously the same. My headquarters was a tent hospital that was just setting itself up not very far from the beaches. When I left every bed was filled, every nurse busy. But even then when they were barely established they were awaiting orders to move forward.

That was the amazing quality of our hospitals in France — their fluidity, their motility and the extraordinary quality of service they maintain under these conditions. Always on the move trying to keep up with the Armies! I chased one hospital halfway across France and never did catch up with it!"

Red Cross Bursaries for Undergraduate Nursing Education

At a recent meeting of the Executive of the Ontario Division of the Canadian Red Cross Society, recommendations of the Nursing Committee were adopted whereby for a period not to exceed ten years, bursaries will be awarded to certain young women resident in Ontario who wish to enrol in an undergraduate degree course in nursing or public health nursing or both in one of the universities of the province.

It will be recalled that following the last great war the Canadian Red Cross Society established courses for graduate nurses in a number of Canadian universities including the University of Western Ontario and the University of Toronto. In the interval, nursing education has broadened until a pressing need is for financial assistance to enable promising students to obtain sound basic preparation for posts of leadership in the various fields of nursing. Provision has been made therefore to set aside for bursaries $25,000 from the peace-time funds of the Division. These will not exceed $1,000 for any one student, except in unusual circumstances, and are given in order that candidates with outstanding qualifications may not be denied this preparation if financially unable to meet the total cost involved.

A committee appointed by the Division will award the bursaries and all universities offering a basic training in nursing will be considered. However, certain educational standards will be required of all university schools or departments enrolling such candidates. The Division has stipulated that following a period of internship the student must agree to serve the Ontario Division in some branch of nursing for at least one year after the completion of the course.

In so doing recognition has been given to voluntary service rendered by the nursing profession in the Division's work over a period of years. Moreover, a unique and signal contribution has been made to sound undergraduate nursing education under university auspices within the province.

—Florence H. M. Emory.

Department of Health and Public Welfare, Manitoba

The following have recently been appointed to the Provincial Public Health Nursing staff: *Lucille Crawford* (Children's Hospital, Winnipeg), with the Dauphin Health Unit; *Patricia Martin* (St. Joseph's Hospital), at Grahamdale; Miss *McLeod* (Grace Hospital), at McCreary; *Janet Kennedy* (St. Anthony's Hospital), at LePas; *E. Radley* (Dauphin General Hospital), at Rorketon; Miss *Cruikshanks* (Neepawa General Hospital), at Flin Flon; Miss *Ward* (Victoria Hospital), at Fisher branch.

The following have returned to the staff after taking courses in public health nursing: *A. Kennedy* (University of Minnesota), at Flin Flon; *A. Spence* (B.Sc., University of Minnesota), at McCauley; *E. Brown* (University of Western Ontario), at Brandon; *J. Williamson* (University of Manitoba), with Dauphin Health Unit. *Lillian Blair*, Alexander, has returned to the staff after three years of service in South Africa, where she was stationed at the military hospital at Potchefstroom. Miss Blair is at present with the Division of Venereal Disease Control.

Ontario Public Health Nursing Service

Oleavia Chant (Buffalo City Hospital School of Nursing and University of Toronto public health course) has resigned her position at Kirkland Lake and accepted the

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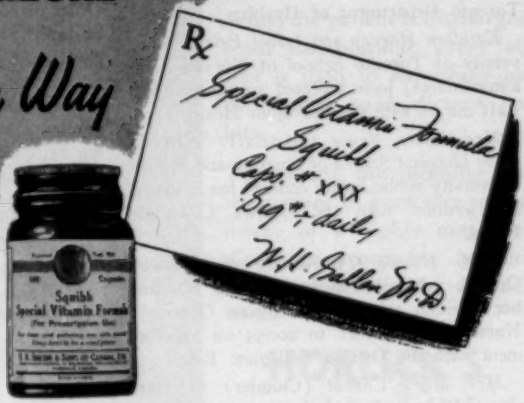

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*National Research Council, Reprint and Circular Series No. 115, Jan. 1943.

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appointment as public health nurse for Milton, Acton and Georgetown.

Ruth McClure (University of Alberta Hospital School of Nursing and University of Alberta public health course) has accepted a staff appointment with the City of Toronto Department of Health.

Kathleen Harvey and *Isabel Petrie* (University of Toronto School of Nursing Diploma Course) have accepted appointments as staff nurses with the Porcupine Health Unit.

Mrs. Eileen Bruce (Bretzlaff) (Ottawa Civic Hospital School of Nursing and McGill University public health course) has resigned her position with the Ottawa Collegiate Board.

Edith Horton (University of Western Ontario public health course) has resigned her position with the Victorian Order of Nurses at Kitchener to accept an appointment with the Ottawa Collegiate Board.

Mrs. Marie Chabot (Cloutier) (University of Western Ontario public health course) is returning to resume her duties with the North Bay Board of Health.

Margaret Penty (St. Joseph's Hospital School for Nurses, Sudbury, and University of Western Ontario public health course) has resigned her position with the Victorian Order of Nurses and has been appointed public health nurse at St. Mary's.

Nancy Craig (Toronto Western Hospital School for Nurses and University of Toronto public health course) has been appointed a staff nurse at Peterborough, having resigned her position in Manitoba.

Essie Kain (Toronto Western Hospital School for Nurses and University of Toronto public health course) has accepted an appointment as staff nurse with the Porcupine Health Unit.

Margaret Turner (Hamilton General Hospital and University of Western Ontario public health course) has resigned her position at Kitchener to accept an appointment with the Wentworth County School Health Unit.

Public Health Nursing Division, Toronto

The following nurses were appointed in 1944 to the Division of Public Health Nursing, Department of Public Health, Toronto:

Graduates of the *Toronto General Hospital* and University of Toronto public health nursing course: Elizabeth Boulter, Eileen Clark, Beatrice Cryderman, Ina Forrest, Margaret Hallawell, Frances Hayhoe, Margaret Mellon, Lillian Wark, Olive Wood.

Graduates of the *Toronto Western Hospital* and University of Toronto public health nursing course: Mary Arneil, Edythe Smith, Lillian Taylor.

Graduates of *St. Michael's Hospital, Toronto,* and University of Toronto public health nursing course: Marie Bedford, Mrs. Pauline McCowatt, Margaret McNamara, Margaret Regan.

Graduates of *University of Toronto School of Nursing*: Mrs. Dorothy Johnston, Mary Willet.

Eileen Balne (Brantford General Hospital), Helen Clarida (Port Arthur General Hospital), Margaret Coburn (Oshawa General Hospital), Doceil Eldred (Saskatoon City Hospital), Agnes Heffernan (St. Joseph's Hospital, London), Doris Holmes (Hospital for Sick Children, Toronto) Leona MacGregor (Bellevue Training School for Nurses, New York), Alice McGee (Oshawa General Hospital), Mrs. Dorothy Marshall (Montreal General Hospital), Mrs. Edna Querrie (Hamilton General Hospital), Marguerite Saxton (Connaught Training School for Nurses, Weston). (All nurses have taken the public health nursing course at the University of Toronto).

Mrs. Edna McLean (Brantford General Hospital and public health nursing course, Simmons College, Boston), Mrs. Mary Scott (Victoria Hospital, London, and public health nursing course, University of Western Ontario), Nance Cuyler (B.Sc.N., University of Alberta).

The following nurses are now on active service: Phyllis Shannon (with the R.C.A.F.); Margaret Smith, Mary Turnbull, Muriel Wright (with the R.C.A.M.C.).

Resignations have been accepted from Jean McWilliam, Ella Ratz, Mrs. Katherine Robinson.

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Victorian Order of Nurses for Canada

The following are the staff appointments to, transfers, and resignations from the Victorian Order of Nurses for Canada:

Bessie Jackson (Ottawa Civic Hospital and public health nursing course, McGill University) has returned to the Order and is in charge of the newly opened branch in Fort William.

May Jeanne MacKay (General Hospital, Brantford, and public health nursing course, University of Toronto), who was previously on the Toronto staff, has returned to the Order and is in charge of the Brantford Branch.

Helen Keith (Ottawa Civic Hospital) and *Clara Weiss* (Holy Family Nursing School, Prince Albert), having completed a two months' period of orientation introductory to Victorian Order nursing, have been posted to Liverpool, N. S. and Timmins, Ontario, respectively.

Gwendolyn Angus (Victoria General Hospital, Halifax) has been appointed temporarily to the Halifax staff.

Mrs. Alma Johnson (University of Alberta Hospital, Edmonton), *Patricia Merriman*, (Holy Cross Hospital, Calgary), and *Regina Cowan* (St. Mary's Hospital, Montreal) have been appointed temporarily to the Montreal staff.

Ruth Kirkpatrick (Hamilton General Hospital) has been appointed temporarily to the Peterborough staff.

Evangeline Saulnier (King's Co. Hospital, Brooklyn, N.Y.) has been appointed temporarily to the Yarmouth staff.

Annie Wade (Victoria Hospital, London) has been appointed temporarily to the Woodstock staff.

Joan Marchand (St. Luke's Hospital, Montreal) has been appointed temporarily to the Lachine staff.

Emelia Longo (St. Joseph's Hospital, Toronto) has been appointed temporarily to the York Township staff.

Mary Dewar (Royal Victoria Hospital, Montreal) has been appointed temporarily to the Kingston staff.

Irene Redman (General Hospital, Oshawa) has been appointed temporarily to the Oshawa staff.

Betty Brown (Victoria Hospital, London) has been appointed temporarily to the Chatham staff.

Merle Pringle (Winnipeg General Hospital) has been appointed temporarily to the Winnipeg staff.

Alfreda Lavoie (Moncton Hospital) has been temporarily appointed to the Moncton staff.

Helen Elizabeth McQuay (Kingston General Hospital) has been appointed temporarily to the Kingston Branch.

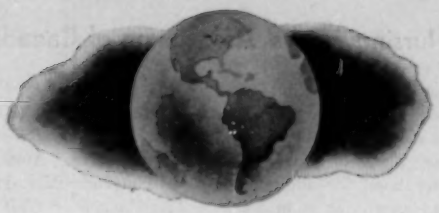
Vera Bruner has been transferred from the Sarnia staff to take charge of the newly opened branch in Kingsville. *Hattie Empey* has been transferred from the Brantford Branch to the Sherbrooke Branch. *Georgina Carr* has been transferred from the Lachine Branch to the Woodstock (Ont.) Branch. *Dorothy Fullerton* has been transferred from the Pictou staff to the Saint John staff. *Margaret Rowe* has been transferred from the Woodstock Branch to the Cornwall Branch.

Ruby Forward and *Mildred Gough* have resigned from the Montreal staff, the former to do other work and the latter to be married. *Dorothy McPherson* has resigned from the Pictou staff to be married. *Lenore Wellar* and *Jessie Lower* have resigned from the Toronto staff. *Jessie Tillett* has resigned from the Sarnia staff to do industrial nursing.

M.L.I.C. Nursing Service

Louise Ahier (Notre Dame Hospital, Montreal) and *Jeanne d'Arc Hamel* (St. Sacrement Hospital, Quebec City) have been appointed to the Metropolitan nursing staff in Montreal.

Marie Anne Chess (Hotel Dieu de St. Joseph, Montreal, and University of Montreal public health nursing course), formerly in charge of the Metropolitan nursing service in Thetford Mines, P. Q., and *Gilberte Violette* (St. Sacrement Hospital, Quebec City, and University of Montreal public health nursing course), formerly in charge of the Metropolitan nursing service in Joliette, P. Q., have resigned from the Company's service.



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ASPIRIN

Nursing Sisters' Association of Canada

As the executive for 1945-46 was not appointed until the middle of November, requests for newsletters did not go out to the various units this year. Therefore the news is not complete but we hope for additional news later. Be sure to watch for it in *The Canadian Nurse*.

At the annual dinner of the *Toronto Unit* in November, five hundred dollars was voted to the "National" Nursing Sisters' Association for purposes of nursing rehabilitation. This fund represents our first post-war effort and it will be the nucleus to which we are confident all units will contribute for the difficult days ahead.

From *Halifax* came Christmas greetings to all sister units. Many Halifax members are busily engaged in aiding the war effort. Their duties include canteen, I.O.D.E., Red Cross, port nursing, sales of poppies, distribution of ration books, community drives. This eastern Canadian port has been a busy spot during the years of the war. The annual dinner and meeting was held November 11 at the attractive home of Miss Laura Hutley, R.R.C. and twenty-seven members had a jolly get-together. Mrs. E. R. Hughes (Gilham) of Kingston, Ont. was a welcome guest. Halifax is proud to have two members of the unit serving again in uniform—Matron M. B. MacNeil, A.R.R.C. of Halifax Military Hospital, and Nursing Sister Marguerite MacLean, A.R.R.C., posted to transport duty across Canada. The sympathy of the club goes out to Nursing Sister MacLean in the loss of her brother in January and to Mrs. E. K. Gillis in the loss of her only son in October, 1944. Officers for 1944-45 include: past president, Marion Haliburton; president, Mrs. W. S. Beattie (Janet Macdonald); vice-president, Josie Cameron; secretary, Edna C. Duthie; treasurer, Lillian Fitzgerald; sick visitor, Jane Hutley.

The *Ottawa Unit* held their annual meeting and Armistice dinner at the Chelsea Club on November 12. Brigadier C. G. Hepburn, M.C., Principal Protestant Chaplain, was guest speaker. He spoke on "Remembrance" and the spirit of comradeship which binds all those who have been associated in the great experiences of war. Miss Blanche Anderson moved a vote of thanks. Col. Elizabeth Smellie, C.B.E., R.R.C., gave a short report on the national convention held in Winnipeg last June. Officers for 1944-45 include: president, Mrs. G. Spalding, R.R.C.; vice-president, Mrs. H. A. Caghill; secretary, Edith Bagnall; treasurer, Annie McNicol, R.R.C.; social convener, Mrs. H. J. Stitt.

The *Vancouver Unit* sent greetings to all nursing sisters in Canada and abroad. At the general meeting in September, Miss E. Gray gave a wonderful report of the national convention in Winnipeg. Sixteen Christmas parcels for husbands and sons of members were sent to various theatres of war. On Remembrance Day an afternoon tea was given at Hycroft to honour the veteran patients. There were several special guests and the husbands of our members. The veterans look forward to this tea as one of the high spots of the year, being entertained by their "sisters". The following Sunday the Overseas Nursing Sisters attended with the Amputation Association the Remembrance Day services in Canadian Memorial Church.

The Local Council of Women, with which we are affiliated, have arranged a short series of radio talks. On December 22, the nursing sisters took charge. Our unit plans to organize group insurance this year. Ninety-nine per cent of our members are working at Red Cross Branches, general duty in hospitals, in the men's service club or in industrial plants, besides retaining their interest and work in the Club. We still retain a box of comforts for the old and new army at Shaughnessy Hospital. This includes socks, sweaters and toilet articles. Chocolates were sent to Miss E. Martin, Edinburgh, for distribution to soldiers and sailors. At a drawing for the British Nurses Relief Fund we realized over $400. A delightful garden party was held at the home of Mrs. Fitz-James and many old acquaintances renewed. Dressings are made at the Red Cross work rooms every Tuesday. Dressing dolls for our booth at the Trafalgar Day fair was of tremendous interest to the club members, and in this way we have kept in touch with nursing sisters all over B. C. This year we excelled ourselves and sent a cheque for $360 to London, England, for the mine sweepers; we do this under the charter of the Ladies Guild, British Sailors Society. The executive for the coming year include: president, E. McLane; vice-president, M. Motherwell; secretary, Mrs. Danby Smith; treasurer, E. V. Camcron; executive members, Mrs. McNutt, B.

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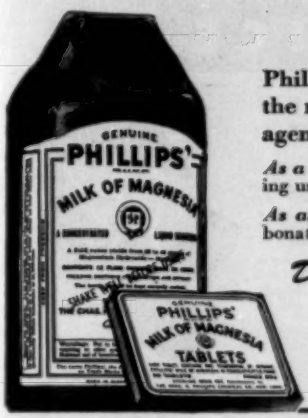

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All units reported attending the Vesper Service in memory of Florence Nightingale and the special services on Armistice Day. In most cases a wreath is placed at the cenotaph. In Ottawa a wreath was also placed by the national executive of the Association.

The officers composing the national executive for 1944-46 are as follows: president, Maude Wilkinson; first vice-president, Isabelle McEwen; second vice-president, Mrs. Grace Gray Wilson; third vice-president, Mrs. C. A. Young; secretary-treasurer, Mrs. Helen Duff Forgan, 55 Highland Cres., York Mills, R.R.2, Toronto.

NEWS NOTES

ALBERTA

PONOKA:

A short business meeting of Ponoka District, No. 2, A.A.R.N., was held recently when the following officers were elected: president, Helen Furnell; vice-president, Mrs. Ragnhild Olsen; secretary-treasurer, Margarethe Lefsrund; representative to *The Canadian Nurse*, Mildred Nelson.

Nessa Leckie, formerly night supervisor at the Provincial Mental Hospital, has been awarded a C.N.A. bursary for post-graduate study, and is taking the course in teaching and supervision at the McGill School for Graduate Nurses. Mrs. R. Olsen (Bohmer) and P. Jamieson, 1944 graduates of Provincial Mental Hospital, have returned to

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the staff as supervisors. Ruth Parfett, formerly secretary-treasurer of Ponoka District, has recently been married. Helen Furnell and Kathleen Metheral returned to the Provincial Mental Hospital staff following the conclusion of the summer school courses in public health and teaching and supervision. Later Miss Metheral proceeded to the Calgary General Hospital as assistant instructor of nurses. Mrs. Lillian Stephenson (Mackie) has returned to the Provincial Mental Hospital staff as night supervisor.

A course in psychiatric nursing is well underway for a small group of graduate nurses.

EDMONTON:

At a recent regular monthly meeting of the Royal Alexandra Hospital Alumnae Association there were sixty-four members present, with the president, Miss Violet Chapman, in the chair. A sum was donated to the Red Cross for prisoners-of-war parcels. A nominating committee was appointed to select officers for the ensuing year. A letter was read from members in Vancouver who have met to discuss the possibility of forming a branch of the Alumnae in that city. There were thirty members present and the honour of cutting a huge cake was given to Mrs. Stella Dawson, of the Class of 1912. News letters have been sent to all members serving in the Armed Forces as well as to members in good standing.

The Rev. Canon A. M. Trendell, rector of All Saints Cathedral, gave us a most informative and interesting report on "Juvenile Delinquency". Canon Trendell is vitally interested in the problems of youth and as judge of the juvenile court speaks with authority on conditions as they exist today.

BRITISH COLUMBIA

VANCOUVER:

At a recent meeting of the Vancouver Chapter, R.N.A.B.C., the guest speaker was Dr. Donald E. Starr. His lecture on "Pinning and Nailing" in orthopedic surgery pointed out the modern trends in that field. Dr. Starr illustrated his lecture by films and pictures. The V Bundle Committee, under the convenership of L. Drysdale, had a display of the children's toys which had been made by various groups. These toys are being sent to England for the British children. E. Brenner, M. Harwood, and C. Hess have recently joined UNRRA.

St. Paul's Hospital:

An open meeting of St. Paul's School of Nursing Alumnae Association for all grad-

uate nurses of Vancouver was recently held. Dr. Elda Lindenfeld, eminent psychiatrist, was the guest speaker and her topic was "Insanity — its Prevention and Cure".

West Vancouver Chapter:

The offer of the West Vancouver Red Cross of the use of their premises for chapter meetings is gratefully accepted. A parcel has been sent to Miss Riddell, a former member, who is now overseas. M. I. Ewart was appointed as representative to the committee investigating the possibility of building a convalescent home for nurses on property at Caulfields.

North Vancouver Chapter:

Miss Johnston has accepted the appointment to act on a committee for post-war planning for epidemics. Mrs. McDonald was appointed to act on the committee to investigate the project for a nurses convalescent home on Caulfields estate.

Smithers Chapter:

The Smithers Chapter is to be congratulated on their "aim for 1945" — to found and operate a well-baby clinic. At a recent meeting an interesting discussion on penicillin was held.

NOVA SCOTIA

Halifax:

Annie B. Brown (Children's Hospital, 1926) has joined the American Air Force Nursing Service and has been stationed at different posts throughout the United States and will proceed overseas in the near future.

ONTARIO

Editor's Note: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Irene Weirs, Department of Public Health, City Hall, Fort William.

District 1

Chatham:

The Kent County industrial nurses invited the personnel managers of their firms to a recent meeting when Philip Alexander spoke

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Scrubbing up leaves hands and arms red and sore — Cutex Hand Cream whitens, soothes and smooths them! Not sticky. Big full-ounce jar for only 39¢!

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or

Miss F. Munroe, R. N., Superintendent of Nurses, Royal Victoria Hospital, Montreal, P. Q.

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on "Oral Vaccines and Vitamins" and special films on venereal disease were shown. Program arrangements were in charge of Mrs. C. I. Salmon and L. Smythe. The December meeting took the form of a dinner with Mrs. Longuay of the Chrysler Corporation, Windsor, speaking on "The Problems for the Young Nurse in Industry". The Kent County Industrial Nurses organization is affiliated with the Public Health Section, R.N.A.O.

Districts 2 and 3

Kitchener:

An enthusiastic meeting of nurses from all parts of Districts 2 and 3, R.N.A.O., was held recently at Freeport Sanatorium. The day was ideal and suitable for travelling to this spot where we were warmly received by the lady superintendent, Miss Alice Bingeman. One hundred and fifty nurses and visitors were registered. Reports from section representatives showed more general interest in the profession throughout the District. Dr. S. J. Hawkins gave an informative address on "Tuberculosis and its Treatment". Miss Margaret Dulmage spoke on *The Canadian Nurse* and gave us some information on the work being done at present by the Red Cross Home Nursing Division. It was decided to purchase a Victory Bond. Following a turkey dinner served by the Sanatorium staff, we were entertained by Mr. William Cowls, of Kitchener, who told us, in his own way, what his plans would be fore post-war problems of the nursing profession. The election of officers later took place. The Spring meeting will be held in Brantford.

The annual meeting of the Kitchener and Waterloo Chapter was held in Waterloo, in the form of a dinner, with Miss Florence Weicker presiding. Forty-six members were present. Miss C. Attwood, of Stratford, who is membership convener of the District association, was present and asked the support of all members in her work. Dr. Olive Matthews, of Kitchener, gave a timely address on civic matters entitled "Is Your House in Order?" The election of officers was carried out, the new chairman being Miss Marie Felpush, Kitchener. Regular meetings are held in the City Hall, Kitchener, on the fourth Tuesday of each month.

Miss F. Weicker, of the Merchants Rubber Company, entertained the Kitchener and Waterloo industrial nurses at the plant at a recent regular meeting. Mr. W. Koehler, industrial relations manager, escorted the group through the factory after having given an interesting demonstration on the building of a rubber shoe. Several new members were welcomed to this meeting, including personnel workers employed by industries in the city. The following new officers were elected: chairman, F. Kudoba, Dominion Electrohome; secretary-treasurer, Nellie Scott, Dominion Tire Co.

Miss Weicker is now attending Waterloo College and E. Schuman has taken her place

at the Merchants Rubber Co. M. Welsh has joined the R.C.A.F. Nursing Service.

District 5

Toronto:

The Ontario Hospital Association annual meeting in Toronto provides a broad interest for the members of District 5, R.N.A.O., as well as for all other nurses who can find it possible to attend. The Nurse Administrative Section this year was of particular interest and was under the chairmanship of Miss Elsie Jones, superintendent of nurses, Wellesley Hospital, Toronto. Miss Isabel Stewart, professor of nurse education, Teachers College, Columbia University, New York, made "Nurse Administration" a very vital interest to all nurses. The well-attended morning session was followed by a luncheon, addressed by Miss Marion Lindeburgh, past president of the C.N.A.

Increased interest of nurses is apparent in this section of the Association, whose board of directors includes for 1945 four members of the R.N.A.O.: Mrs. Muriel Cariss (McKee), Brantford, past president; Priscilla Campbell, Chatham, third vice-president; and Pearl Morrison, Toronto. Louise Acton, of Kingston, is also a member as nurse representative.

Miss Isabelle McEwen, director of nursing, Red Cross Outpost Hospitals of Ontario, has been appointed a member of the committee to assist Dr. R. P. Vivian, Minister of Health for Ontario, to develop a "comprehensive over-all plan for hospitalization" for Ontario. Acute necessity is present for this project due to shortage of needed hospital beds.

Miss Jean Masten, superintendent of nurses, Hospital for Sick Children, Toronto, as president of the R.N.A.O., has been appointed the nursing representative on the Municipal Health Service Board authorized under the recently passed Municipal Health Services Act in Ontario. Members of the Board represent both those receiving services and those providing them.

Toronto General Hospital:

Miss Edna Moore recently addressed the T.G.H. staff meeting on "Nursing — Today and Tomorrow". A reception followed.

At a recent meeting of the Alumnae Association Miss Margaret Aitken, of the *Toronto Evening Telegram* staff, gave a most interesting address on "A Newspaper Woman at Three War Conferences" from her own personal experience. At the reception which followed Lt.-Col. Agnes Neill, Matron-in-Chief, R.C.A.M.C. Overseas, who is home on leave from England, brought greetings to her Alumnae.

Toronto Western Hospital:

At a recent general staff meeting, Dr. A.

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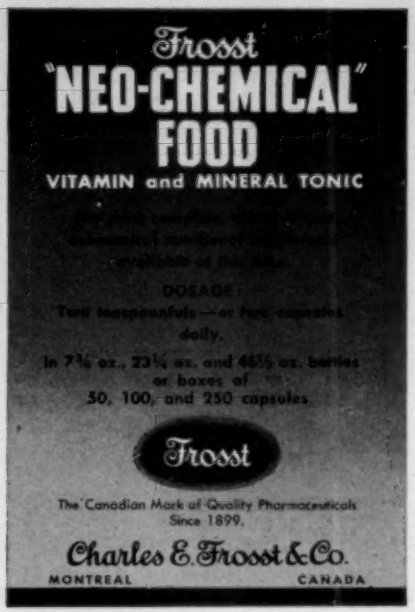

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W. White, recently returned from the Mediterranean theatre of war, presented an illustrated lecture on "Fractures and their Treatment". The importance of exercise in the restoration of function to an involved joint is not fully realized, and few hospitals are equipped to give adequate treatment.

The Alumnae Association recently held a very successful tea at the Edith Cavell Residence. At a recent meeting Dr. A. I. Willinsky showed his latest technicolor film entitled "Mexicana". Scenes of life in Mexico were portrayed in a very realistic and colourful way.

Christmas parcels were sent to the forty-two graduates of the School now serving overseas with the R.C.A.M.C. Two scholarships have been awarded by the Association for one year's post-graduate study at a university, the recipients being Muriel Scrace for public health nursing, and Peggy Wood, clinical supervision in surgery.

Grant Macdonald Training School:

It has been the annual custom for the Grant Macdonald Training School Alumnae Association to serve afternoon tea to those attending the Christmas sale of work done by the patients of the occupational therapy department of the Queen Elizabeth Hospital on Dunn Avenue. This year the event was of necessity curtailed but a very satisfactory amount was realized. A raffle of a lovely pair of wool blankets made philanthropic activities secure for some time to come.

This Alumnae Association, of a School which has been discontinued, is called upon to take a normal part in nursing activities with decreasing numbers, instead of increasing. It is very gratifying to know that one can continue to take part under such conditions.

District 7

A meeting of District 7, R.N.A.O. was recently held at the Ontario Hospital, Rockwood, with fifty nurses present. Reports were read from the different chapters and sections. Dr. John Wylie, Professor of Preventive Medicine at Queen's University, gave an instructive and interesting illustrated talk on his public health experiences in Guatemala. Dr. Wylie was one of a party of ten doctors who went to Gautemala this past summer to study tropical disease, and his talk served to stress the widespread interest in public health today.

The attention of the meeting was directed to the new Community Health Council, Kingston, which is promoting a community recreation hall for the young people of Kingston. The support of the members was requested in the coming city election with respect to the need for the proposed community hall, and Miss Connelly, public health nurse, and Miss L. Gill of the Isolation Hospital, were appointed to sit on the Community

Health Council. Later, refreshments were served by Miss Smith, superintendent of nurses, and her staff.

The Kingston Chapter has held one meeting with an attendance of sixty members, including several Nursing Sisters from No. 3 Military Hospital. The topic for discussion was occupational therapy, stressing the value it has in pediatrics, tuberculosis, orthopedics, Workmen's Compensation Board Clinic, and military and mental hospital fields.

The Brockville Chapter has been holding regular monthly meetings since October. Topics such as "Administration of Penicillin" and "Oxygen Therapy" have been discussed.

Brockville General Hospital:

The Alumnae Association of the Brockville General Hospital recently held a dance with the orchestra from the officers training centre at Brockville providing the music. Part of the proceeds were used for Christmas boxes which were sent to nurses serving overseas. During the last Victory Loan drive the Association invested in a Bond. Two prizes were given at the graduation this year and, in co-operation with the Board of Governors, the graduating class was entertained. New furniture has been purchased for the Alumnae Room in the hospital as well as three service tables for the Brockville International Blood Donor Clinic.

The following officers have been elected to serve during the coming year: honourary presidents, Alice Shannette, Edith Moffatt; president, Mrs. Mae White; first vice-president, Mrs. Wm. Cooke; second vice-president, Lucy Merkley; secretary, Mrs. Howard Bishop; corresponding secretary, Maude Arnold; treasurer, Mrs. H. Vandusen; conveners: gift, Violet Kendrick; social, Mrs. H. Green; property, Mrs. M. Derry, J. McLaughlin, M. Gardiner; annual fees, Vera Preston; representative to *The Canadian Nurse*, Helen Corbett.

District 8

Ottawa:

A well-attended refresher course, entitled "The Nurse's Responsibility in the Care of the Obstetrical Patient" was conducted by District 8, R.N.A.O., on December 11, 12, and 13, and held at the Civic and General Hospitals. On the first day Dr. Couture spoke at both sessions on Prenatal Care, and the Nursing Care was conducted at the afternoon session by Edith Stevenson, and at the evening session by Kate McIlraith, V.O.N., Ottawa.

The topic for December 12 was Labour and Dr. John Puddicombe was the speaker at the General Hospital, followed by Viola Downie who spoke on Nursing Care. At the Civic Hospital Dr. R. E. D. Cargill was the speaker and was ably assisted by Mary

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An examination for the title and certificate of Registered Nurse of British Columbia will be held April 17, 18, and 19, 1945.

Names of Candidates for this examination must be in the office of the Registrar not later than March 17, 1945.

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On the last day Dr. W. J. Stevens discussed the Post-partum Period and H. O'Meara, University of Ottawa, discussed the Nursing Care. The evening session at the Civic Hospital was conducted by Dr. Puddicombe and the Nursing Care discussed by L. Barry, supervisor of the nursery at the Civic Hospital.

These lectures were most instructive and it was felt by all who attended that in the future their obstetrical patients would receive more intelligent nursing care.

QUEBEC

Montreal General Hospital:

A recent visitor to the School was Bernice I. Kent, director of the pediatric department, Hahnemann Medical College and Hospital, Philadelphia. Miss Kent has recently been appointed a director with the United States Cadet Nurse Corps.

Genevieve T. Piette (B.Sc. Columbia University), formerly with the Brooklyn Visiting Nursing Association and the Indian Service, and recently with the U.S.P.H.S. as public health staff nurse with the Balkan Mission, has now been appointed to UNRRA. Alison G. Reid has been appointed nurse-in-charge of the dental clinic, Central Division, replacing Helen Miller who resigned. Madeleine I. Carr has joined the physical therapy staff, Central Division. Her work is associated with artificial fever therapy.

McGill School for Graduate Nurses:

The general meeting of the Alumnae Association was held recently when the students of the McGill School for Graduate Nurses were entertained at a Dessert Party, previous to the meeting.

Recent visitors to the School were Louise Bartsch, Ethel Grindley, Helen Saunders, Grace Martin, Elizabeth Westren, Helen Leak, and Nursing Sisters Lois Bird, Alice Palmquist, Jeannine Coupal.

QUEBEC CITY:

Jeffery Hale's Hospital:

Miss E. Frances Upton recently addressed a meeting of the Alumnae Association when she spoke on the highlights of the past biennial meeting, and discussed the organization of District 9 of the R.N.A.P.Q. A special meeting was called for the organization of the aforementioned district. Captain Hall recently addressed a meeting of the Association on "Adult Psychology". The Christmas formal dance was held at the end of December. All students who wrote the Fall R.N. examinations passed successfully. N/S

MacIver and I. Greenwood (Henderson) recently returned from overseas.

SASKATCHEWAN

HUMBOLDT CHAPTER:

A course in first aid was given at Muenster under the direction of Mrs. O. A. Saddlemyer, Commandant, Emergency Nursing Reserve. It is worthy of note that Humboldt is the leading town in the Saskatoon District in the support given to blood donor clinics. Nurses assist at each of these.

MOOSE JAW CHAPTER:

Nurses in this Chapter were responsible for eleven parcels sent to nursing sisters overseas. An interesting meeting when "Our Relationship to South America" was the subject of an address is also reported.

PRINCE ALBERT:

A meeting and Christmas party was held at the Prince Albert Sanatorium at which Mrs. Maggie Stephen was hostess. Forty-two nurses attended. Plans for the extension of the registry were discussed. Mrs. Verna McCrory presided.

REGINA:

A welcome illustration of the desire of nursing sisters to maintain contacts with their professional association is shown in an invitation received by the Regina Chapter to meet at the Nursing Sisters Mess, M.D. No. 12, when an interesting address was given on the "Inter-relationship between Social Work and Public Health Nursing" following which refreshments were served by the nursing sisters.

The Regina Chapter also reports the resignation of Mrs. D. Rowe, night registrar, and the appointment of Grace Moyer to this position.

SASKATOON:

Advantage was taken at a recent meeting of an educational film, made available through the Audio-Visual Branch of the Department of Education, entitled "Windbreaks on the Prairies", depicting methods of soil conservation through the planting of trees. "White Battlefront", outlining a city's defence against disease, also proved of great interest.

The Catholic nurses of Saskatoon have formed a Catholic Nurses Association and are organizing study groups.

Mrs. Elfrieda Schroeder has accepted the position of clinical instructor at St. Paul's Hospital. Lola Pearsall is taking the public health nursing course at the University of Toronto School of Nursing.

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Refresher Course in Nova Scotia

A refresher course in Public Health is to be held at two centres in Nova Scotia — in Halifax from February 19 to 24 and in Sydney from February 26 to March 3. This course is to be conducted by the Public Health Section of the Registered Nurses Association of Nova Scotia with Miss Mary Mathewson, Assistant Director of the McGill School for Graduate Nurses, as the speaker.

—F. M. BENNETT

Refresher Courses

During the past autumn, the School of Nursing, University of Toronto, included four refresher courses in its busy program. A four-day series on the teaching of home nursing was attended by eighty-seven prospective instructors. An intensive course in industrial nursing, covering one week, was very stimulating to the 139 registrants. Twelve persons participated in an extension course in obstetrics which was spread over a period of two months. A lecture course in administration and supervision in nursing, with lectures given once a week from October to March, is being attended by fifty nurses.

Health Week in February

Many Canadian communities at the request of the Health League of Canada will observe a Health Week in February, the observance to coincide with the holding of National Social Hygiene Day, February 7. Health Week will open Sunday, February 4.

Purpose of the "Week" is to bring messages to Canadians on health as a basic factor in their lives — personal, communal and national. The League contends that only a nation of optimum health can discharge fully such great international responsibilities as will have to be undertaken by the Dominion in the coming year.

Endorsation of the Health Week plan already has been received from departments of education and health in six provinces. Also, churches, schools, home and school associations and numerous women's and other organizations and service clubs have indicated a desire to co-operate in the extensive and ambitious program which is in course of preparation.

—*Health News Service.*

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Mr. William S. McIntyre, Secretary, Saint John District Board of Health, Saint John, N. B.

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R. F. Swanston, Secretary-Treasurer, Hythe District Nursing Association, Hythe, Alta.

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